Mid-Term Clinical Evaluation

Radiologic Technology Program

INDIANHILLS COMMUNITY COLLEGE
Life. Changing.

Student's Name: _____ Date: _____

Clinical Facility: _____

Clinical: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7**

Fill out and return each mid-term. Comments are **required** to support mid-term rating.

Clinical Instructor Mid-Term Evaluation				
☐ 1 Does Not Meet Expectations	☐ 2 Below Average Expectations	☐ 3 Average Expectations	☐ 4 Above Average Expectations	☐ 5 Exceeds Expectations
Comments:				

Clinical Instructor's Signature: _____ Date: _____

Clinical Coordinator Mid-Term Evaluation				
☐ 1 Does Not Meet Expectations	☐ 2 Below Average Expectations	☐ 3 Average Expectations	☐ 4 Above Average Expectations	☐ 5 Exceeds Expectations
Comments:				

Clinical Coordinator's Signature: _____ Date: _____

Students must have completed at least 50% of their competencies to be considered passing at Mid-Term.

_____ PASS _____ FAIL

Student's Signature: _____ Date: _____