**Prisma Health Medical Group**

**Annual Provider/Faculty Evaluation**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Department:** |  |
| **Evaluation Year:** |  | **Practice Location:** |  |

**If you hold a USC Faculty Title, please select your Title:** Professor

**If you hold a USC Faculty Rank, please check your status:**

Tenured [ ] Non-Tenured [ ] Adjunct [ ] Affiliate [ ] Not applicable [ ]

**Percent Effort:** (based on a 40 hour work week)

* Patient Care (cFTE) 
* Administration\Leadership (aFTE) 
* Teaching (eFTE) 
* Research/Scholarly Activity (rFTE) 

**TOTAL** 100%

**Instructions**

Each section heading covers a type of activity that is performed within your department. Please fill out any areas that are applicable to you, or check “not applicable” then leave blank any areas that do not apply to you. For example, if you only do clinical work providing patient care, you would only fill out the patient care and possibly administrative sections.

Please attach the following supporting documents if applicable (all in electronic format)

* Current CV (academic faculty required, all encouraged)
* Peer teaching evaluations summary (academic faculty required, others optional)
* Medical student evaluations (academic faculty required others optional)
* Resident/Graduate Student Evaluations (academic faculty required, others optional)

**Patient Care [] Not Applicable**

Number of scheduled clinic half days :\_\_\_\_\_\_\_\_

Type of patient care activities (list)–\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take call? ( Y / N )

Do you take home call with potential in-facility duties when called? ( Y / N )

Do you take in-facility call? ( Y / N )

To be filled in by administration:

Clinical productivity measure: \_\_\_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Chart Completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quality Indicators­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Administration / Leadership [] Not Applicable**

Committees (note if departmental, medical group, hospital, school, university, or other)

Administrative Activities (not educational)

Department Citizenship

Extramural Professional Service (e.g., grant reviews, editorial boards, professional associations, etc.)

Other Activities /Honors (including community and volunteer - List)

**Teaching [] Not Applicable**

Undergraduate Students (include course designator and hours if known )

Medical Students

Graduate Students (include course designator and hours if known)

Residents/Fellows/Postdoctoral Students

CME/Faculty Development

Teaching done outside of the department

Educational administrative responsibility (give full correct title, i.e. "Assistant Director of Medical Student Education")

Other Activities (List)

**Research/Scholarly Activity [] Not Applicable**

Grants/Contracts funded

Grants/Contracts not funded (include submitted)

Refereed Publications (include accepted)

Books/Book Chapters (include accepted)

Presentations

Abstracts

Funding of Research Time (Expectation: 100% funding of research time)

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Other Activities (List)

**Team Member Self-Assessment (All)**

Self-Assessment Instructions - Self-Evaluation Areas

1. Professional development

What activities have you undertaken for professional growth in the past year? What are your professional goals for the upcoming year?

2. Participation in practice goals, operational improvements, Medical Group Leadership?

What has your participation been in this process? Describe any success or challenges you have experienced. What are your plans for next year?

3. Barriers?

Are there barriers within the practice or the health system as a whole that complicate your work in any of the areas above? What would you be able to do if these barriers were not present? Do they affect everyone in the same way or just apply to your situation? What suggestions do you have to remove these barriers?

**Team Member Development (All)**

What are your professional development needs?

**Division Head / Chairman Designee Summary Comments (if applicable)**

**Chairman Summary Comments (All)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Provider Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Department Chair or Designee Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Dean or Designee if required Date**