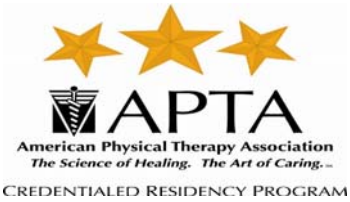

Kaiser Permanente Rehabilitation Services
Postprofessional Residency in Neurological Physical Therapy

Weekly Mentoring Feedback Form

Resident's Name: _____ _____

Week beginning: _____

Date(s) of mentoring: _____

Total number of hours spent mentoring with this resident during this week: _____

Mentor's Name(s): _____

Mentoring occurred in the following setting(s) (circle):

Rehab Hospital SNF/ECF Outpatient LTC Other (list):

Facility: _____

Type(s) of patient(s) seen (diagnostically):

_____

_____

Specific areas in which the resident performs well:

_____

_____

_____

_____

_____

_____

Specific areas in which the resident needs to improve:

_____

_____

_____

_____

_____

_____

TO BE COMPLETED BY RESIDENT:
Resident's comments/action plan (sure other side if needed):

_____

_____

_____

_____