

Intern Final Evaluation

Intern's name _____ Date _____

Primary on-site campus _____

Primary Clinical Instructor _____ Day Phone _____

Dates of Internship from _____ to _____

Description of Program:							
Evaluate on a scale from 1 to 5 [1 = Needs improvement 5 = Excellent]						Comment on strengths and weaknesses in each category	
						Strengths	Weaknesses
History Taking	1	2	3	4	5		
Maternal Assessments	1	2	3	4	5		
Infant Assessments	1	2	3	4	5		
Feeding Assessments	1	2	3	4	5		
Plans of Care	1	2	3	4	5		
Charting	1	2	3	4	5		
Follow-up	1	2	3	4	5		
Counseling Skills	1	2	3	4	5		
Professionalism	1	2	3	4	5		
Overall Strengths for practicing as an IBCLC							
Overall Weaknesses for practicing as an IBCLC							

