

University of Missouri – Columbia
School of Health Professions
Department of Physical Therapy

MID-TERM REPORT FORM

Please fill out the information below and send back to the DCE in the envelope provided.

Facility Name: _____

Student Name: _____

Clinical Instructor Name: _____

Is the student having any difficulty in the following areas:

- | | | |
|-------------------------------|-----------|----------|
| 1. Safety | Yes _____ | No _____ |
| 2. Professional behavior | Yes _____ | No _____ |
| 3. Ethical and legal practice | Yes _____ | No _____ |
| 4. Attendance | Yes _____ | No _____ |

Student: Please fill in the appropriate information:

Graduation Year: _____

Affiliation (please circle):

1 2 3 4

Do you feel that significant changes need to be made before you would feel comfortable giving this student a “passing” grade on this affiliation?

Yes _____ No _____

Comments if checked “yes”:

Would you like a formal phone visit with the DCE?

Yes _____ No _____

If yes, when is the best time to reach you? _____