COLLEGE OF MEDICINE & DENTISTRY AT THE HILLS
ABBOTTABAD

Logbook 5th Year MBBS

For Recording Practical And Clinical Activities

Year
2025-26

About the student

Name of the student:

Father`s name:

Class:

Year of induction into CMDH

Address:

Contact no. of student:

Contact no. of father / guardian:

Email:

Contents

Dean`s Message

The systematic observation and assessment of medical students are essential to the curriculum. This requires diverse assessment methods and supervised clinical exposure. To accurately evaluate and grade student performance, a reliable record of these activities is mandatory.

For decades, the logbook has been a globally recognized tool in medical education for this purpose. While traditional logbooks can be susceptible to data falsification, they remain a valuable checklist for tracking student activities and performance.

To streamline teaching, assessment, and certification, the College of Medicine & Dentistry at the Hills, Abbottabad, is introducing a logbook for students in their 5th year and beyond. This system will structure and record clinical rotations against defined learning objectives, providing a clear basis for faculty assessment. This initiative is a foundational step toward a future comprehensive portfolio system.

CMDH, Abbottabad

Purpose of Logbook

This Logbook is intended to develop, record, assess, and certify students' activities during clinical and other rotations in the 5th Year. These activities are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides objective evidence during the assessment of students and the evaluation of the overall performance of the institution and curriculum. Adding reflection by students during the activity log enhances the academic performance of students. A section of reflection had been added to this log book with the intent to convert this document into a reflective portfolio in future. Record of these activities will ultimately improve patient safety, as the students will be aware of their limits, duties and responsibilities.

Objectives of clinical rotations

Clinical rotation is one of the integral parts of undergraduate medical students that usually start in the 5th year. However, in contemporary programs, rotations in clinical activities starts right at the start of training as part of integration attempt. This document will be extended in future amongst students of early years. Clinical skills learning requires the exposure of students into clinical environment. This exposure should be preceded by skill laboratory training, and should be gradual. It has to be according to the learning objectives defined in the curriculum. The objectives of these rotations include:

1) Application of concepts in real life situations which is being given in lectures, books and other reading materials
2) Acquisition of clinical skills relevant to the level and understanding of students
3) Understanding the concepts of patient safety, hospital organization and roles of doctors in clinical situations
4) Developing communication skills, patient management skills, team work, time management skills, and interdepartmental collaboration at workplace
5) Developing and enhancing professionalism in medical students

It is important to mention that this logbook is not only intended for the above-mentioned purposes, but include other activities and accomplishments of students like research, presentations and record of participation in co-curricular activities.

How to use this Logbook

The log book is divided into sections according to the specialties and units whom the students visit. Rotation in each unit is represented into 3 parts; 1st part represents clinical skills required of students, 2nd part relates to other activities like knowledge imparted during rotation, record history taking, field visits, assessment marks and student`s reflection. The 3rd part includes attributes of communication skills and professionalism. All the students are required to dully attest each activity in the log book. The log book also includes record of activities not related to clinical rotations. Those activities include, presentation skills, record of research publications, co-curricular activities and many others. At the end, there is record of student's attendance, and end of module assessment marks that should be completed by the student affairs / examination section. This log book will have an important weightage in final assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to make a copy of all these activities so that it can be retrieved in times of loss of log book at the end of the year. It is important to mention that level of competence has been shown in individual rotations as follows:

Level A: Observer status
Level B: Assistant status
Level C: Performed part of the procedure under supervision
Level D: Performed whole procedure under supervision
Level E: Independent performance

Third year students will achieve only level A and B in most of the situations except a few where patient safety is not endangered. Students of 4th and 5th year are required to achieve level C and D and in some cases level E (where patient safety is not endangered).

Methods of writing Reflection in the Logbook

Reflective thinking and writing demands that you recognise that you bring valuable knowledge to every experience. It helps you therefore to recognise and clarify the important connections between what you already know and what you are learning. It is a way of helping you to become an active, aware and critical thinker and learner.

It is mandatory for students to write about his / her experience and reflective thinking of clinical rotation in each unit in the space given in logbook. The reflective document includes the description about the following points:

1) Description of an event (one paragraph)
2) Thinking and feeling of student (one paragraph)
3) Good and bad about the experience (one paragraph)
4) How to avoid bad experiences and pursue good experiences in future (a few words to a paragraph).

The whole reflection document should be about between 200-300 words

Contents of clinical rotations

In 5th year, the MBBS students are rotated in following departments in groups of about 15 students:

1) Medicine
2) Surgery
3) Gynaecology
4) Orthopedics
5) ICU (Pulmonology)
6) CCU (Cardiology)

In the next sections, a list of competencies, level of achievement, professionalism attributes and supervisor`s observations / approval with dates are mentioned.

General Medicine

Medical A unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in medical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		Pulse Oximeter placement						
5		Nasogastric tube insertion						
6		Foley`s catheter insertion						
7		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms in General Medicine	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)	Topic: Date: Name of teacher	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Medical B unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in medical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		Pulse Oximeter placement						
5		Nasogastric tube insertion						
6		Foley`s catheter insertion						
7		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms in General Medicine	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news role play	Role play	
End of ward assessment	Marks _____out of_____	
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Medical A unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in medical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		Pulse Oximeter placement						
5		Nasogastric tube insertion						
6		Foley`s catheter insertion						
7		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms in General Medicine	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Medical B unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in medical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		Pulse Oximeter placement						
5		Nasogastric tube insertion						
6		Foley`s catheter insertion						
7		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms in General Medicine	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Medical A unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in medical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		Pulse Oximeter placement						
5		Nasogastric tube insertion						
6		Foley`s catheter insertion						
7		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms in General Medicine	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

General Surgery

Surgical A unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First aid						
5		• Nasogastric tube insertion						
6		• Foley`s catheter insertion						
7		• Wound care including D/D						
		• Apply bandage / splint						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in General surgical practice	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Surgical B unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First aid						
5		• Nasogastric tube insertion						
6		• Foley`s catheter insertion						
7		• Wound care including D/D						
		• Apply bandage / splint						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in General surgical practice	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	**No**	**Any other point**	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Surgical A unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First aid						
5		• Nasogastric tube insertion						
6		• Foley`s catheter insertion						
7		• Wound care including D/D						
		• Apply bandage / splint						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in General surgical practice	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	**No**	**Any other point**	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Surgical B unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First aid						
5		• Nasogastric tube insertion						
6		• Foley`s catheter insertion						
7		• Wound care including D/D						
		• Apply bandage / splint						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in General surgical practice	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	**No**	**Any other point**	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Surgical A unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in surgical unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4		• First aid						
5		• Nasogastric tube insertion						
6		• Foley`s catheter insertion						
7		• Wound care including D/D						
		• Apply bandage / splint						
		• Others (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in General surgical practice	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
How to write Daily Progress Report (SOAP plan)		
How to write discharge summary (SBAR protocol)		
Counselling / breaking bad news	Role plays	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Gynecology and Obstetrics

Gynae A unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in Gynae / Obs. unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Vaginal / Pelvic examination Obstetric examination						
		•						
		•						
		•						
		•						
		• Other (specify)						
4		Deliveries • Normal vaginal						
5		• Forceps						
6		• C. Sections						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in Gynae / Obs.	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Session conducted on following: • Labor notes • Neonatal assessment • Placenta • Partograph • Post-delivery Daily progress reports	By:	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
Antenatal visits protocol	Presented by:	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Gynae B unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in Gynae / Obs. unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Vaginal / Pelvic examination / Obstetric examination						
		•						
		•						
		•						
		•						
		• Other (specify)						
4		Deliveries • Normal vaginal						
5		• Forceps						
6		• C. Sections						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in Gynae / Obs.	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Session conducted on following: • Labor notes • Neonatal assessment • Placenta • Partograph • Post-delivery Daily progress reports	By:	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
Antenatal visits protocol	Presented by:	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Gynae A unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in Gynae / Obs. unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		Vaginal / Pelvic examination / Obstetric examination						
		•						
		•						
		•						
		•						
		• Other (specify)						
4		Deliveries • Normal vaginal						
5		• Forceps						
6		• C. Sections						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in Gynae / Obs.	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Session conducted on following: • Labor notes • Neonatal assessment • Placenta • Partograph • Post-delivery Daily progress reports	By:	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
Antenatal visits protocol	Presented by:	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Pediatrics

Pediatrics A unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in Paeds. unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Dehydration status						
		• Examination of newborn ❖ Physical screening ❖ Hip examination						
		• Others (specify)						
r3		Growth parameters						
		• Height / length						
		• Weight						
		• Head circumference						
		• Use of centile charts						
		•						
		• Role play / counseling session						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
History taking- presentation	Presented by:	
Resuscitation (manikins)	Presented by:	
Growth parameters	Presented by:	
Exchange transfusions	Presented by:	
Integrated management of neonatal and childhood illnesses (IMNCI-under 2 months) / fever / sepsis / jaundice	Presented by:	
Advantages of breast feeding	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Pediatrics B unit

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		History taking from a patient in Paeds. unit						
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Dehydration status						
		• Examination of newborn ❖ Physical screening ❖ Hip examination						
		• Others (specify)						
r3		Growth parameters						
		• Height / length						
		• Weight						
		• Head circumference						
		• Use of centile charts						
		•						
		• Role play / counseling session						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
History taking- presentation	Presented by:	
Resuscitation (manikins)	Presented by:	
Growth parameters	Presented by:	
Exchange transfusions	Presented by:	
Integrated management of neonatal and childhood illnesses (IMNCI-under 2 months) / fever / sepsis / jaundice	Presented by:	
Advantages of breast feeding	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)	Topic: Date: Name of the patient:	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Nephrology

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		CVP / double lumen insertion						
		• Renal U/S						
		• RENAL BIOPSY						
		•						
		•						
		• Other (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Nephrotic syndrome / nephritic syndrome/ Acute kidney injury / chronic kidney disease	Presented by:	
hemodialysis	Presented by:	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Orthopedics

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
2		History taking						
		General physical examination						
		•						
		•						
		•						
		• Others (specify)						
3		Application of cast						
		• X-ray reading						
		•						
		•						
		•						
		• Other (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to common problems in Orthopedics	Presented by:	
Management of fractures	Presented by:	
Orthopedic emergencies	Presented by:	
Details of 2 patient's histories and physical examination	Presented by:	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

CCU and Cardiology

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
2		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3		• ECG						
		• Echo						
		• ETT						
		• Temporary pacemaker insertion						
		• Use of defibrillator						
		• Other (specify)						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
BCLS	Presented by:	
ACLS	Presented by:	
OTHERS: 1-	By:	
2-	By:	
3-	By:	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

ICU and Pulmonology

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
2		General physical examination						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Examination of respiratory system						
3		• Bronchoscopy						
		• Ventilator						
		• Endotracheal intubation						
		• PFTs						
		• DLCO						
		• Sleep studies						
		• others						

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Introduction to oxygen therapy (modes, indications, limitations)	Presented by:	
Introduction to artificial ventilation (modes, indications, limitations, weaning)	Presented by:	
Respiratory failure	Presented by:	
End of the ward assessment	Marks: _____out of _____	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

Other academic and co-curricular activities

List of presentations*

S. No	Title of presentation / lecture	Venue	Date	Signature of supervisor / organizer

*The student can paste photocopies of certificates of presentations on this page

List of certificates of participation in other academic and co-curricular activities*

S. No	Name of activity / society / other	Position	From ----to (date)	Signature of organizer / incharge

*Student can paste the proof / certificate / office order of the activities / events

For examination section

Details of marks of internal assessments

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book				**Out of: 50**			
	%age							

Deputy / Controller of examination

Sign_____

Director Medical Education

Sign_____