

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

Please fill out the information below and fax or mail back to the DCE in the envelope provided.
Fax (573) 884-8369

MID-TERM REPORT FORM

Facility Name: _____

Student Name: _____

Clinical Instructor Name: _____

Clinical Instructor Phone Number: _____

Clinical Instructor Email: _____

Student: Please fill in the appropriate information:

Graduation Year: _____

Affiliation (please circle):

1 2 3 4 5

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 ___ |

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”:

