

AFFILIATING EXPERIENCE EVALUATION
Student Form (Clinical, Precept, Observation)

We would appreciate your cooperation in evaluating the affiliating experience your students have just completed. The information you provide will be used in an attempt to improve future affiliations.

TITLE OF AFFILIATING PROGRAM: _____

AFFILIATING INSTITUTION: _____

UNIT OR AREA TO WHICH ASSIGNED: _____

DATES OF CLINICAL EXPERIENCE: _____

For each of the following statements, please indicate whether you “Strongly Agree” (SA), “Agree” (A), “Disagree” (D), “Strongly Disagree” (SD).

Objectives of Affiliating Experience

- | | | | | |
|--|----|---|---|----|
| a. The staff on the unit were welcoming and treated me with respect. | SA | A | D | SD |
| b. The staff on the unit was helpful. | SA | A | D | SD |
| c. The unit environment facilitated my learning. | SA | A | D | SD |
| d. I would recommend this facility to other students. | SA | A | D | SD |

Comments: _____

