University of Pennsylvania
School of Nursing

TEACHING RESIDENCY EVALUATION

Name: ________________________________________  Date: ___________________

Advisor/Chairperson: _____________________________________________________

Advisor/Chairperson Signature: __________________________________________

Faculty Preceptor Signature: (if different) ___________________________________

Semester in which Teaching Residency was completed: _______________________

Directions: Please list your teaching residency objectives and for each objective please list the activities that you completed to meet the objective.

Teaching Residency Objectives:

Activities to Meet Each Objective:

Signature: _______________________________________ Date: ___________________

Graduate Group Chair