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