Appendix A

SUNY Upstate University Hospital

PROCTOR EVALUATION FORM

Practitioner Name	
Proctor Name	
Proctoring Date(s)	
Proctored Procedure(s)	
Level of Proctoring *1. Prospective* *2. Concurrent*	
Number of Cases and/or Duration	
Describe the Type of Cases Observed	
Please Evaluate the Practitioner's Performance	
1. Clinical knowledge *a. General background information* *b. Indications and contraindications* *c. Physiology and pathophysiology* *d. Anatomy* *e. Limitations of the practitioner* f. *Economics*	
2. Knowledge of the equipment *a. Technical aspects of the equipment* *b. Specific details of the equipment* *c. Operating details of the equipment* d. *Safety aspects of the equipment*	
3. Knowledge of the procedure *a. Physical characteristics of the procedure* *b. Technique of the procedure* *c. Preparation of the patient* *d. Precautions and potential complications* *e. Limitations of the procedure* *f. Special techniques* *g. Advanced techniques*	
4. Judgement during Procedure	
Other Comments or Concerns *Proctors must report if the case is stopped due to potential harm to the patient, or if the proctor is called upon to act as the assistant surgeon.*	

______________________________ ________________

Proctor Signature Date

Return form to Medical Staff Services via fax (315-464-8524) or e-mail (medstaff@upstate.edu).

Appendix B

SUNY Upstate University Hospital

PROCEDURE TRACKING

Practitioner Name: ______________________________ Proctor Name: ______________________________

CASE #		PROCEDURE	DETAIL	COMPLICATIONS / NOTES
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No
			Patient #: Date:	□ Yes (please explain): ____________ ____________ □ No

I certify that the above accurately reflects the cases and procedures I have performed, and submit the above as documentation of competence for the procedures I am requesting. A copy of the consent form for each case is attached; I understand that incorrectly completed consent forms will make the involved case ineligible for consideration as a proctored case.

______________________________ ______________________________

Signature Date

I attest that the above accurately reflects the cases and procedures I observed as a proctor, and that I have verified by review of the case logs for these procedures that in and out times for the proctored practitioner and myself for each procedure were accurately documented. I will submit the Proctor Evaluation Form with my assessment of the above cases.

______________________________ ______________________________

Signature Date

* ***Return form to Medical Staff Services via fax (315-464-8524) or e-mail (medstaff@upstate.edu).***