**Pediatric Cardiology Standardized Letter of Evaluation – RESIDENCY PD/APD Version**

***Instructions:***

- ***For residency program directors/associate program directors – please complete the following form in lieu of a traditional letter of recommendation.***
- ***For pediatric cardiologists – the "PEDIATRIC CARDIOLOGIST" version may be used in lieu of a traditional letter of recommendation.***
- ***All other references, please submit your traditional letter of recommendation as usual.***

****When uploading your completed SLOE to the AAMC Letter of Recommendation Portal (LoRP), please select the box indicating "This is a SLOE."**

**Applicant Name**:
**AAMC ID**:
**Evaluator Name**:
**Evaluator Role**: ☐ Residency Program Director ☐ Residency Associate Program Director
**Email**:

1. **Individualized Curriculum/Experience – please list number of weeks or "NA" as applicable for this applicant (required)**

| Rotation | Weeks | |
|---|---|---|
| | **Program Minimum** | **Applicant Total (completed + scheduled)** |
| NICU | | |
| PICU | | |
| Cardiology – Inpatient | | |
| Cardiology - Ambulatory | | |
| Additional cardiology electives (i.e. CICU, echo, away rotations) | | |
| | | |
| Does your program have defined subspecialty preparatory tracts or other subspecialty-related curriculum for residents interested in fellowship training? | ☐ Y | ☐ N |
| *If "YES", did/will this applicant complete the cardiology preparatory tract? | ☐ Y | ☐ N |
| **If "YES", please attach that curriculum/rotation list or other pertinent documents in lieu of filling out the weeks in the table above. | | |

| Does your program utilize a pre- or post-grad chief resident? | | | |
|---|---|---|---|
| ☐ 3rd year pediatric chief | ☐ 4th year pediatric chief (additional year post-peds graduation) | ☐ Med-Peds with 4th year chief | ☐ 5th year med-peds or peds chief (additional year post med-peds graduation) |

2. **Competency levels (required) - please rate this applicant using your historical experience with residents at an equivalent point in training**

| | Bottom 25% | Bottom 50% | Top 50% | Top 25% | Top 10% | Top 5% | Top 1% | Not observed |
|---|---|---|---|---|---|---|---|---|
| Medical knowledge - Mastery of pathophysiology, critical thinking, diagnostic reasoning | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Clinical skills – Hx-taking, PE proficiency, clinical decision making, management of acute/complex patients | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Professionalism/Work Ethic – reliability, integrity, accountability, response to feedback, commitment to personal development, timely non-clinical task completion, self-guided learning | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Communication/Team-Work – Effectiveness with patients/families, interdisciplinary communication, collegiality | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Adaptability/"Grit factor" – resilience, persistence through adversity, response to stress, response to change in environment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Scholarly Potential – Commitment to and participation in research, quality improvement, and medical education | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

3. **Please highlight the top one or two notable strengths of this applicant (required)**:

**4. Please select this applicant's top two ongoing areas for improvement (required):**

| | | | | |
|---|---|---|---|---|
| ☐ Fund of knowledge | ☐ Time management | ☐ Situational awareness | ☐ Teamwork | ☐ Professionalism |
| ☐ Leadership skills | ☐ Communication skills | ☐ Recognizing own limitations | ☐ Adapting to different clinical/learning environments | ☐ Self-directed learning and self-improvement |
| ☐ Organizational skills; multitasking | ☐ Personality considerations | ☐ Punctuality | ☐ Preparedness | ☐ Response to feedback |
| ☐ Scholarly engagement | ☐ Performance under stress | ☐ Timely completion of non-clinical requirements | ☐ Overconfidence | ☐ Under confidence |
| ☐ Other (please do not answer "none" or "nothing"): | | | | |

**Please elaborate on your reasons for choosing the selected options (required):

**5. Readiness and Likelihood of Success in Pediatric Fellowship (required)**

How confident are you in this applicant's ability to succeed in a pediatric fellowship?

- ☐ Enthusiastically recommend – outstanding candidate
- ☐ Strongly recommend
- ☐ Recommend without reservation
- ☐ Recommend with some reservation (please elaborate below)
- ☐ Do not recommend (please elaborate below)

**Please elaborate on your selection (if applicable):

**6. Additional summative comments (optional):**

Evaluator Signature: _____ Date:

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**7. Categorical Program Characteristics**

| | | | | |
|---|---|---|---|---|
| *Categorical Program Type* | ☐ General Pediatrics | | ☐ Medicine-Pediatrics | |
| *Program size (all training years included)* | ☐ <30 | ☐ 30-50 | ☐ 51-100 | ☐ >100 |
| *Program setting* | ☐ Community | | ☐ Academic | |
| | | | | |
| *Pediatric cardiology faculty full-time at the primary training site* | ☐ Y | | ☐ N | |
| *Pediatric CT surgery at the primary training site* | ☐ Y | | ☐ N | |
| *Internal peds cardiology fellowship* | ☐ Y | | ☐ N | |