

**UNIVERSITY OF RHODE ISLAND
DEPARTMENT OF KINESIOLOGY
210 FLAGG ROAD, 109
KINGSTON, RHODE ISLAND 02881-0810
PHONE NUMBER: 401-874-5438
FAX NUMBER: 401-874-4215**

Date: _____

To: Internship Supervisors

Subject: Mid-Semester Evaluation

Student: _____ **START DATE:** _____

Placement Site: _____ **END DATE:** _____

Please complete, sign and return this mid-term evaluation form. The date to be announced in syllabus and will be stated to you by the student. Please elaborate where appropriate. Also, it would be helpful to your intern to meet with you and review this evaluation. Please have the student sign in the designated space on the second page. Thank you.

1. Do you have a copy of the Agency Acceptance Form? Yes___ No___

2. Is the intern accomplishing her/his goals & objectives? Yes___ No___
Please elaborate:

3. Has your agency/office been able to provide professional opportunities for the student? Yes___ No___

4. Is the student meeting his/her expectations? Yes___ No___
If no, please elaborate:

5. How often do you meet with the intern? _____

6. Does the intern maintain a 34 hour (fall/spring) 40 hour (summer) per week schedule? If no, please explain:

8. Do you see any need to make adjustments to the internship at this time? Yes___ No___

If yes, please call the KIN 484 Director at 401-874-5438.

9. Is a visit/telephone conference by Internship Staff necessary at this time? Yes___ No___

If yes, please call the KIN 484 Director at 401-874-5438.

Supervisor's name (printed)_____

Supervisor's Signature:_____Date:_____

Student's Signature:_____Date:_____

*The student should supply the supervisor with a stamped envelope addressed to the KIN 484 Director in which the supervisor is to send a copy of this completed form.

Thank you