



DE LA SALLE
MEDICAL AND HEALTH SCIENCES INSTITUTE

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OFFICE OF THE
VICE CHANCELLOR
 FOR ACADEMICS

OVCA FORM 135: ADMINISTRATOR'S EVALUATION OF FACULTY

COLLEGE / PROGRAM: _____
 _____ Semester, School Year _____

Name of Faculty	Full Time / Part Time / Fixed Term	Subject / Course Taught	Date of Observation	Signature of Faculty
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10				

 Printed Name of Administrator & Signature
 (With designation, ex. Dean, Program Director, Chair, Vice Chair, etc.)

Date of Submission: _____

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