#

# **Course Title**

# Course Date

1. **Participant Demographic**

[ ]  Physician (MD/DO)

[ ]  RN/LPN

[ ]  Mid-level Practitioner (CNP, CRNA, PA)

[ ]  Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Was information** **presented during this CME activity scientifically sound and free of commercial bias\* or influence?**

**[ ]** Yes

[ ]  No If no, please explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Commercial bias is defined as a speaker promoting use of a specific drug or device without support from evidence produced by scientific research conducted in a manner generally accepted by the scientific community. Commercial support of a CME Activity does not necessarily mean that the CME activity or any presentation was necessarily biased.*

1. **The speakers’ affiliations were disclosed, or it was disclosed that they have no affiliations with commercial companies.**

**[ ]** Yes

 [ ]  No

1. **Were your personal objectives met?**

**[ ]** Yes

[ ]  No

1. **Is the content of this activity likely to influence your practice habits?**

**[ ]** Yes

[ ]  No

1. **Please rate each item below:**

**Day 1 Date**

| **Speaker:** **Topic:**  | **Strongly Disagree****(1)** | **Disagree****(2)** | **Neutral****(3)** | **Agree****(4)** | **Strongly Agree****(5)** |
| --- | --- | --- | --- | --- | --- |
| The speaker's delivery of the content was clear and well organized. |  |  |  |  |  |
| The speaker provided information that I will be able to use in my practice. |  |  |  |  |  |
| **Speaker:** **Topic:**  | **Strongly Disagree****(1)** | **Disagree****(2)** | **Neutral****(3)** | **Agree****(4)** | **Strongly Agree****(5)** |
| The speaker's delivery of the content was clear and well organized. |  |  |  |  |  |
| The speaker provided information that I will be able to use in my practice. |  |  |  |  |  |
| **Speaker:** **Topic:**  | **Strongly Disagree****(1)** | **Disagree****(2)** | **Neutral****(3)** | **Agree****(4)** | **Strongly Agree****(5)** |
| The speaker's delivery of the content was clear and well organized. |  |  |  |  |  |
| The speaker provided information that I will be able to use in my practice. |  |  |  |  |  |

**Day 2 Date**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Speaker:** **Topic:**  | **Strongly Disagree****(1)** | **Disagree****(2)** | **Neutral****(3)** | **Agree****(4)** | **Strongly Agree****(5)** |
| The speaker's delivery of the content was clear and well organized. |  |  |  |  |  |
| The speaker provided information that I will be able to use in my practice. |  |  |  |  |  |
| **Speaker:** **Topic:**  | **Strongly Disagree****(1)** | **Disagree****(2)** | **Neutral****(3)** | **Agree****(4)** | **Strongly Agree****(5)** |
| The speaker's delivery of the content was clear and well organized. |  |  |  |  |  |
| The speaker provided information that I will be able to use in my practice. |  |  |  |  |  |
| **Speaker:** **Topic:**  | **Strongly Disagree****(1)** | **Disagree****(2)** | **Neutral****(3)** | **Agree****(4)** | **Strongly Agree****(5)** |
| The speaker's delivery of the content was clear and well organized. |  |  |  |  |  |
| The speaker provided information that I will be able to use in my practice. |  |  |  |  |  |

1. **Please rate the impact of the following objectives:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *As a result of attending this activity, I am better able to:* | **Strongly Disagree****(1)** | **Disagree****(2)** | **Neutral****(3)** | **Agree****(4)** | **Strongly Agree****(5)** |
| <objective 1> | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| <objective 2> | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| <objective 3> | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

**8. How likely are you to change or implement a patient management strategy in your practice or engage in some other change in your professional work?**

 [ ]  Highly Likely [ ]  Somewhat Likely [ ]  Not Likely

**9. Now that you have participated in this CME/CE activity, please take a moment to consider making changes in your practice as a result. The categories listed below represent potential areas of improvement.**

**Commitment to Change Areas (select all that apply)**

|  |  |
| --- | --- |
| [ ]  Diagnosis and Screening | [ ]  Safety |
| [ ]  Treatment | [ ]  Teamwork-Roles and Responsibilities |
| [ ]  Clinical-Patient or Interprofessional Communication | [ ]  Patient Education |
| [ ]  Quality Improvement | [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  | [ ]  None |

1. **List the specific, measurable change(s) you plan to make:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **On a scale from 1-10, how confident are you that you will be able to make this change?**

Not at all likely Neither likely nor unlikely Extremely likely

 **1 2 3 4 5 6 7 8 9 10**

1. **Please indicate barriers, if any, in implementing these changes.**

|  |  |
| --- | --- |
| [ ]  None | [ ]  Team structure |
| [ ]  Clinical knowledge/skill/expertise | [ ]  Patient characteristics/factors |
| [ ]  Peer influence | [ ]  Patient adherence |
| [ ]  Cultural competence | [ ]  Work overload |
| [ ]  Recall, confidence, clinical inertia | [ ]  Referral process |
| [ ]  Motivation | [ ]  Culture of Safety |
| [ ]  Fear, legal concerns | [ ]  Practice process |
| [ ]  Roles and responsibilities | [ ]  Cost/funding |
| [ ]  Communication | [ ]  Not enough time |
|  [ ]  Competence | [ ]  Lack of opportunity |
|  [ ]  Shared values and trust | [ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. **What might you do to address barriers you encounter?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Suggestions for future activities/topics:**

In order to design future education that can help improve practice, we need to better understand your clinical challenges. Please respond to the following questions:

**In what clinical areas do you feel the least prepared or most uncomfortable?**

**What patient problems or systems issues would benefit from more education or follow up?**

15. COMMENTS:

Please return completed evaluations to the conference registration desk.

Thank you for completing this evaluation form. We consider all responses as we strive to provide the best possible educational experience.