**EVALUATION FORM**

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| --- | --- |
| **Program Title:** |  |
| **Date:** |  |

**Your comments are very important to us! Please complete this evaluation so that we may provide more quality programs in the future.**

**Expected Clinical Outcomes**

1. Will participation in this program result in improving your clinical practice?  Yes  No
2. If yes, please specify changes you intend to make in your practice.
3. Will participation in this program result in improving patient outcomes?  Yes  No
4. If yes, please specify how.
5. Please rate your confidence in implementing these changes.

High confidence  Moderate confidence  Low/No confidence  N/A

1. Please identify any barriers you perceive in implementing these changes (select all that apply)

Cost  Insurance/reimbursement issues

Lack of time to assess/counsel patients  Patient compliance issues

Lack of administrative support/resources  Lack of consensus of professional guidelines

Other - please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How will you address these barriers to implement changes in knowledge and behavior?

**Basic Program Evaluation**

5 = Excellent / 4 = Good / 3 = Average / 2 = Fair / 1 = Poor

1. The material was presented at an appropriate level. 5 4 3 2 1
2. I have gained knowledge that will improve patient care. 5 4 3 2 1
3. The program met my expectations in accomplishing the stated educational objectives. 5 4 3 2 1
4. The program content was objective, balanced, and free from commercial bias or influence. 5 4 3 2 1
5. Your overall rating of the quality of the education offered at this program. 5 4 3 2 1
6. Additional Comments/Explanations:
7. How can this program be improved? (Please list both strengths and weaknesses.)
8. Based on your educational needs, please provide us with suggestions for future program topics and formats: