**EVALUATION FORM**

|  |  |
| --- | --- |
| **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: