**EVALUATION SUMMARY**

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

\*\* Enter the **number of responses for each answer** and **compile all attendee comments under free response questions**. \*\*

**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:

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

**Basic Program Evaluation**

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| --- | --- | --- | --- | --- | --- |
|  | **5** | **4** | **3** | **2** | **1** |
| 1. The material was presented at an appropriate level. |  |  |  |  |  |
| 1. I have gained knowledge that will improve patient care. |  |  |  |  |  |
| 1. The program met my expectations in accomplishing the educational objectives. |  |  |  |  |  |
| 1. The program content was objective, balanced, and free from commercial bias or influence. |  |  |  |  |  |
| 1. Your overall rating of the quality of the education offered at this program. |  |  |  |  |  |

1. Additional Comments/Explanations:
2. How can this program be improved? (Please list both strengths and weaknesses.)
3. Based on your educational needs, please provide us with suggestions for future program topics and formats: