**COURSE TITLE**

**Course day, Course date**

**FACULTY EVALUATION**

Please evaluate today’s presentations by circling the appropriate rating; 5 = excellent, 1 = poor.

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| --- | --- | --- | --- | --- | --- |
| **Talk 1**  **Talk 2**  **Talk 3**  **Talk 4**  **Talk 5**  **Talk 6**  *Please rate session attended:*  2:15p.m.  **Breakout 1**  **Breakout 2**  **Breakout 3**  3:45 p.m.  **Breakout 1**  **Breakout 2**  **Breakout 3** | Content was relevant to my practice  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No | My knowledge of the topic has increased  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1 | Talk presented in clear/organized manner  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1 | Key points were summarized  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1 | Talk was  evidence-based  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1  5 4 3 2 1 |

**Was the information/material presented at this CME activity free from commercial bias? Yes No**

**If no, please explain:**

**Did you learn new information and strategies that you can apply to your work or practice?  Yes No**

**If yes, please describe:**

**Please indicate any barriers you perceive in implementing the changes identified above:**

* No barriers Reimbursement/insurance issues
* Patient compliance issues Cost
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty \_\_\_\_\_\_\_\_\_\_ Type of practice: \_\_\_MD/DO \_\_\_\_NP \_\_\_PA \_\_\_\_RN \_\_\_\_Resident \_\_\_\_\_\_\_\_Other

Years in practice \_\_\_\_\_\_\_\_\_\_ Have you attended this conference previously? \_\_\_\_Yes \_\_\_\_No