



Presented by: \_\_\_\_\_

Location: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

Upon completion of this activity, the participant should be able to:

WHERE APPLICABLE, PLEASE CIRCLE THE NUMBER WHICH BEST REPRESENTS YOUR EVALUATION OF THE SPEAKER(S) AT THIS ACTIVITY:

	Unsatisfactory		Satisfactory		Excellent
1. Accomplishment of specified objectives	1	2	3	4	5
2. Speaker knowledgeable on topic	1	2	3	4	5
3. Topic clearly presented	1	2	3	4	5
4. Visual Aids	1	2	3	4	5
5. Stimulation of discussion	1	2	3	4	5

Speakers are required to disclose whether or not they have financial interests that might bias their presentations.

Was the speaker's actual or potential conflict of interest disclosed to the audience prior to the presentation?

\_\_\_\_\_ yes \_\_\_\_\_ no

How will attending this activity change your practice of medicine?

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

ADDITIONAL EVALUATION COMMENTS:

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

SUGGESTIONS FOR FUTURE ACTIVITIES:

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

Please check one of the following:

\_\_\_\_ Physician      \_\_\_\_ Physician Assistant      \_\_\_\_ Nurse Practitioner      \_\_\_\_ Resident

\_\_\_\_ Other (Please Specify) \_\_\_\_\_



Presented by: \_\_\_\_\_

Location: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

Upon completion of this activity, the participant should be able to:

WHERE APPLICABLE, PLEASE CIRCLE THE NUMBER WHICH BEST REPRESENTS YOUR EVALUATION OF THIS ACTIVITY:

	1=Poor	2=Fair	3=Good	4=Excellent
1. Consistency with stated objectives	1	2	3	4
2. Speaker knowledgeable on topic	1	2	3	4
3. Clarity of topic presentation	1	2	3	4
4. Facilitation of discussion	1	2	3	4
5. Time allowed for questions	1	2	3	4
6. Appropriateness of depth and material	1	2	3	4
7. Pace/length of sessions	1	2	3	4
8. Quality of handout material	1	2	3	4

Speakers are required to disclose whether or not they have financial interests that might bias their presentations. Was the speaker's actual or potential conflict of interest disclosed to the audience prior to the presentation?  
 \_\_\_\_\_ yes      \_\_\_\_\_ no

What change(s) will you make in your medical practice as a result of attending this program? \_\_\_\_\_

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COMMENTS/SUGGESTIONS FOR FUTURE ACTIVITIES: \_\_\_\_\_

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Please check one of the following:

\_\_\_\_ MD, DO    \_\_\_\_ PhD    \_\_\_\_ Resident    \_\_\_\_ Other (Please Specify) \_\_\_\_\_