PLEASE FILL OUT AND HAND IN AT END OF SESSION (Appendix Ia)
NASSAU UNIVERSITY MEDICAL CENTER (or sponsoring organization)

CME COURSE EVALUATION

PROGRAM TITLE: _____DATE: _____

SPEAKER: _____

Please indicate your title and specialty (by checking on the line and circle or fill in where appropriate).

_____ Attending (MD/DO/DPM/DDS/DMD)
_____ Resident (Pediatric/Internal Medicine/Family Practice/OBGYN/Dental/DO/Other)
_____ PA/NP/RN/LPN/PCA/RT
_____ Student (Medical/Nursing/Respiratory/Lab Tech
_____ Other (i.e. Social worker)

PROGRAM (1= Not at all; 2= Only in part; 3= To a good extent; 4= Very much so)

	1	2	3	4
Were objectives met?				
The program addresses problems I face in my practice				

SPEAKER (1= Poor, 2= Fair, 3=Satisfactory, 4= Good, 5= Excellent N/A= Not applicable

	1	2	3	4	5	N/A
Content of the talk was informative and interesting and presented in clear concise manner						
Speaker was thoroughly familiar with the subject.						
Quality of the audio/visual (sound and slide format) was						

Would you invite this speaker again? ☐ No ☐ Yes

Today's session(s) and presenter(s) was free from discussion of any commercial product or service, ☐ No ☐ Yes
If NO (check all that apply)

1.☐ Unbalanced view of therapeutic options
2.☐ Failure to use generic names
3.☐ Use of single brand name vs several
4.☐ Company product promotion was seen
5.☐ Failure to disclose product recommended for off label use or still investigational

Disclosure statements were made: ☐ by the speaker/moderator prior to the activity ☐ in printed material.

This program: (check all that apply)

1.☐ Will alter my practice performance
2.☐ Won't alter my performance, but convinced me I'm doing the right thing
3.☐ Will be relevant to my practice
4.☐ Will not be relevant to my practice
5.☐ Will result in better patient outcomes
6.☐ Did not satisfy my expectation
7.☐ Satisfied my expectations

List three things that you have learned from this program:

_____
_____
_____

The overall program was: ☐ Excellent ☐ Good ☐ Satisfactory ☐ Fair ☐ Poor

Would you like to see this session repeated next year? ☐ No ☐ Yes

Will you make any changes in practice as a result of the CME activity? ☐ No ☐ Yes
If Yes, please describe a specific change you will make_____

Content covered will improve my competencies in: (check all that apply)

☐ Patient care
☐ Medical knowledge
☐ Practice-based learning and improvement
☐ interpersonal communication skills
☐ Professionalism
☐ System-based practice

List suggested topics/speakers for future programs:

_____

Name: _____