

## CME Evaluation and Credit Claim Form

**Activity Title:** \_\_\_\_\_

**Date & Location:** \_\_\_\_\_

St. Vincent's Health System is committed to excellence in continuing education. Your opinions are critical to us in this effort.

**Please note: a CME Transcript is issued only upon receipt of this completed evaluation form. PLEASE PRINT**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Facility** \_\_\_\_\_

**Email**  Yes, I am willing to participate in a 3 month post-activity outcomes survey, email address is: \_\_\_\_\_

**Degree:**  MD  DO  PharmD  PA  Other

The minimum, standard questions asked on CME activity evaluations are as follows:

- 1.) Did this conference meet your educational needs? *Yes/Somewhat/No*
- 2.) Did the information presented reinforce and/or improve your current skills? *Yes/Somewhat/No*
- 3.) Did the information presented provide new ideas/information you expect to use? *Yes/Maybe/No*

Please rate the projected impact of this CME activity on your competence, performance, and/or patient outcomes:

- This activity increased my competence\*. *No Increase/Moderate Increase/Great Increase*
- This activity will improve my performance\*\*. *No Impact/Moderate Impact/High Impact*
- This activity will improve my patient outcomes. *No Impact/Moderate Impact/High Impact*

\* *Competence is defined as giving physicians new abilities/strategies/knowledge with a strategy, or what a professional would do in practice if given the opportunity.*

\*\* *Performance is defined as helping physicians modify their practices.*

Did the speaker meet the objectives?  Yes  No

What other topics in this content area would be beneficial to your learning needs?

\_\_\_\_\_

<b>Speaker(s) Session</b>	<u>Speakers knowledge of Subject Matter</u> <input type="checkbox"/> Outstanding <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<u>Quality of Presentation &amp; Handouts</u> <input type="checkbox"/> Outstanding <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<u>Overall Conference</u> <input type="checkbox"/> Outstanding <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<b>Comments on Conference:</b>			
<b>Intent to Make Practice Changes</b> Please identify 2 <u>specific</u> strategies that you intend to make and incorporate into your practice as a result of attending this activity/session.			
1.			
2.			

In addition to time and money, what barriers might impede the implementation of these strategies?

\_\_\_\_\_

<b>Commercial Bias, Support &amp; Disclosure</b>	
Was this presentation free of commercial bias? Financial disclosures acknowledged?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any commercial promotional products displayed or distributed? Any off-label drug use, and/or investigational drug use not yet approved by the FDA?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA

**REQUEST FOR CREDIT**

If you wish to receive credit for this activity, please return this form to the registration desk upon your departure.

<input type="checkbox"/> I participated in the entire activity and claim <input type="text"/> credits.	<input type="checkbox"/> I participated in part of the activity and only claim partial credits based on <input type="text"/> hours of instruction. (e.g., 4.25, 4.5, 4.75)
<input type="checkbox"/> By checking the box, I certify the above is true and correct.	
Signature: _____	
<b>WE NO LONGER PROVIDE CERTIFICATES.</b> In order to receive a transcript, please call (205) 930-2802 and a transcript will be mailed to you before the end of the year.	