St. Vincent's Health System CME Continuing Medical Education

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?

_____

Speaker(s) Session	Speakers knowledge of Subject Matter ☐ Outstanding ☐ Good ☐ Average ☐ Fair ☐ Poor	Quality of Presentation & Handouts ☐ Outstanding ☐ Good ☐ Average ☐ Fair ☐ Poor	Overall Conference ☐ Outstanding ☐ Good ☐ Average ☐ Fair ☐ Poor
Comments on Conference:			

Intent to Make Practice Changes

Please identify 2 specific 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?

_____

Commercial Bias, Support & Disclosure		
Was this presentation free of commercial bias? Financial disclosures acknowledged?		☐ Yes ☐ No
Any commercial promotional products displayed or distributed? Any off-label drug use, and/or investigational drug use not yet approved by the FDA?		☐ No ☐ Yes ☐ NA

REQUEST FOR CREDIT

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

☐ I participated in the entire activity and claim ☐ credits.	☐ I participated in part of the activity and only claim partial credits based on ☐ hours of instruction. (e.g., 4.25, 4.5, 4.75)
☐ By checking the box, I certify the above is true and correct.	
Signature:	

WE NO LONGER PROVIDE CERTIFICATES.

In order to receive a transcript, please call (205) 838-3225 and a transcript will be mailed to you before the end of the year.

FAX: (205) 838-3518