St. Vincent's Health System

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. To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please reflect carefully and complete this evaluation form. ***Please note: a CME transcript is issued only upon receipt of your completed evaluation form.***

We may need to contact you! Please fill out the information below.

PLEASE PRINT:

Name: ____

INDIVIDUAL SPEAKER EVALUATIONS

Please use the following rating scale:

5 - Outstanding 4 – Good 3 - Average 2 - Fair 1 – Poor

Speakers Session I ***Date*** ***(List Speakers Below)***	**Knowledge of Subject Matter**	**Appropriateness of Teaching Strategies**	**Was Presentation Free of Commercial Bias?**
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:

Speakers Session 2 ***Date*** ***(List Speakers Below)***	**Knowledge of Subject Matter**	**Appropriateness of Teaching Strategies**	**Was Presentation Free of Commercial Bias?**
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:
	5☐ 4☐ 3☐ 2☐ 1☐	5☐ 4☐ 3☐ 2☐ 1☐	☐ Yes ☐ No If no, please describe:
Did you have the opportunity to discuss practice-relevant issues with the speakers?			☐ Yes ☐ No
Has this activity met your identified needs and professional practice gaps?			☐ Yes ☐ No
Please rate the overall impact of this activity objectives on:			
	High Impact	Moderate Impact	No Impact
Knowledge	☐	☐	☐
Competence	☐	☐	☐
Performance	☐	☐	☐
Patient outcomes	☐	☐	☐

CONTENT

On a scale of 1-5, please rate the following:	**1-Strongly Agree**	**2- Agree**	**3-Neutral**	**4-Disagree**	**5-Strongly Disagree**
The program met the identified objectives.	❑	❑	❑	❑	❑
The program was effective in addressing and closing identified practice gaps					
The content was relevant to my educational needs.	❑	❑	❑	❑	❑
The program was well-structured and organized.	❑	❑	❑	❑	❑
The over-all quality of the activity met my expectations.	❑	❑	❑	❑	❑
How might the format of this activity be improved in order to most appropriate for the content presented?	Comment:				

COMMERCIAL SUPPORT AND DISCLOSURE

	YES	NO
Presentations were given without bias or conflict of interest.	❑	❑
Disclosure of faculty relationships with commercial organizations was made available to me before the presentation	❑	❑
The commercial supporters were acknowledged in the printed materials	❑	❑
If trade names were used, trade names of all products discussed were used	❑	❑
Representatives of commercial supporters did not engage in sales activities in the meeting room before, during, or after the activity	❑	❑
Commercial promotional products were not displayed or distributed in the meeting room	❑	❑
Any off-label drug use, and/or investigational drug use not yet approved by the FDA was disclosed before or during the activity	❑	❑
If you answered "No" to any of the above questions, please provide details in the comments section below:		

OUTCOME

On a scale of 1-5, please rate the following:	1-Strongly Agree	2- Agree	3-Neutral	4-Disagree	5-Strongly Disagree
Attending this activity improved my:					
Knowledge of the subject.	❑	❑	❑	❑	❑
Competence (the ability to apply the knowledge).	❑	❑	❑	❑	❑
Performance (what is actually done in practice).	❑	❑	❑	❑	❑

INTENT TO MAKE PRACTICE CHANGES

Please identify two specific strategies that you learned as a result of attending this activity:
1.
2.

Beneficial Topic/Idea

What **one** topic or idea from the conference did you feel was the most **beneficial** to you?

Future Educational Needs

Based on your needs what areas would you like to see addressed at future CME programs?

[PLEASE NOTE: THIS PAGE IS USED TO OBTAIN SUMMARY INFORMATION AND YOUR NAME WILL NOT BE DISTRIBUTED TO FACULTY]

Degree: ☐ MD ☐ DO ☐ PharmD ☐ RN ☐ PA ☐ BS ☐ Other

REQUEST FOR CREDIT

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

☐ I participated in the entire activity and claim ☐ credit hours.

☐ I participated in only part of the activity and only claim partial credit hours based on ☐ hours of instruction.
(e.g., 4.25, 4.5, 4.75)

☐ You have permission to contact me in approximately three months to determine if I was able to implement changes in my practice as a result of this CME activity.
(contact me by ☐ email ☐ fax)

☐ By checking the box, I certify the above is true and correct.

Please Print Clearly

Name

Specialty

Street Address

City ***State*** ***Zip Code***

Phone Number

Fax Number

E-mail

WE NO LONGER PROVIDE CERTIFICATES.
In order to receive a transcript, please call (205) 838-3225 otherwise a transcript will be mailed to you before the end of the year.