

Conference Evaluation Form

Title: _____

Date: _____

Speakers: _____

1. Please rate the impact of the following objectives:

As a result of attending this activity, I am better able to:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Objective #1:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Objective #2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Objective #3:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Please rate the projected impact of this activity:

<i>This activity:</i>	Yes	No	No Change	If yes, please describe:
Increased my knowledge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Increased my competence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Improved my performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Will improve my patient outcomes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

*The Accreditation Council for CME requires us to analyze changes in learners' competence, performance, or patient outcomes.

3. Please answer the following:

	Yes	No	Please explain:
Speaker(s) were knowledgeable regarding content.	<input type="checkbox"/>	<input type="checkbox"/>	
There was an opportunity to discuss practice-relevant issues with the speakers	<input type="checkbox"/>	<input type="checkbox"/>	
Presentation(s) were balanced, objective, and scientifically rigorous	<input type="checkbox"/>	<input type="checkbox"/>	
Content of this activity matched my current (or potential) scope of practice.	<input type="checkbox"/>	<input type="checkbox"/>	
Activity was scientifically sound.	<input type="checkbox"/>	<input type="checkbox"/>	
Activity was free of commercial bias or influence.	<input type="checkbox"/>	<input type="checkbox"/>	

4. Please identify how you will change your practice as a result of attending this activity (select all that apply).

- | | |
|--|--|
| <input type="checkbox"/> Change protocols, policies, and/or procedures
<input type="checkbox"/> Change the management and/or treatment of my patients | <input type="checkbox"/> Other change, please specify: _____

<input type="checkbox"/> No changes--activity validated my current practice |
|--|--|

5. Have you participated in activities on this topic in the past? Yes No

5a.. If yes, has it impacted your practice? Yes No Explain _____

6. Please indicate any barriers you perceive in implementing these changes.

Lack of:

- Finances
- Time
- Experience
- Opportunity (patients)
- Resources

- Administrative support
- Reimbursement/insurance
- Patient adherence
- Professional consensus or guidelines

Other, please specify: _____

No barrier

7. Will you address these barriers in order to implement changes in your competence, performance, and/or patients' outcomes? N/A

Yes – Explain _____

No – Explain _____

8. Please indicate which of the following American Board of Medical Specialties/Institute of Medicine core competencies were addressed by this educational activity (select all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Patient care or patient-centered care | <input type="checkbox"/> System-based practice | <input type="checkbox"/> Medical knowledge |
| <input type="checkbox"/> Interpersonal and communication skills | <input type="checkbox"/> Interdisciplinary teams | <input type="checkbox"/> Employ evidence-based practice |
| <input type="checkbox"/> Practice-based learning & improvement | <input type="checkbox"/> Quality improvement | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Professionalism | <input type="checkbox"/> Utilize informatics | |

9. How might the format of this activity be improved for the content presented (select all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Add hands-on instructional component | <input type="checkbox"/> Schedule more time for Q and A |
| <input type="checkbox"/> Include more case-based presentations | <input type="checkbox"/> Other, describe: _____ |
| <input type="checkbox"/> Increase interactivity with attendees | |
| <input type="checkbox"/> Add breakouts for subtopics | <input type="checkbox"/> No changes needed: format was appropriate |

10. Please describe any:

Exceptional presentations _____

Presentations not meeting your needs/expectations: _____

Clinical situations that you would like to see addressed in future educational activities: _____

**Please return completed evaluations to the appropriate representative.
Thank you.**