EVALUATION FORM

# (TITLE OF ACTIVITY)

 (Venue and City/State where Activity is held)

(Date of Activity)

1. Approximate percentage of patients you manage for the topic(s) addressed by this activity?

[ ]  0-20% [ ]  21-40% [ ]  41-60% [ ]  61-80% [ ]  81-100%

2. The content was appropriate to my practice:

[ ]  Strongly Disagree

[ ]  Disagree

[ ]  Neutral

[ ]  Agree

[ ]  Strongly Agree

3. The activity was free of commercial bias. [ ]  Yes [ ]  No

 If you answered “no” to the above question, please explain:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. The activity met the following objectives:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| OBJECTIVES | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| 1. Objective #1 |  |  |  |  |  |
| 2. Objective #2 |  |  |  |  |  |
| 3. Objective #3 |  |  |  |  |  |
| 4. Objective #4 |  |  |  |  |  |

5. Will information presented during this activity lead you to change(s) in your current practice?

[ ]  Yes [ ]  No [ ]  Not sure at this time

6. If yes, what will you change? *The following are examples. Please update to reflect correct information for your activity*

[ ]  Utilize new techniques available for breast reconstruction.

[ ]  Apply new assessment strategies in facial rejuvenation cases

[ ]  Utilize alternative techniques to ADM (acellular dermal matrix)

[ ]  Utilize tram flaps during breast reconstruction.

[ ]  Modify approach to skin envelope and pocket development.

[ ]  No Change

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. What barriers do you foresee that might interfere with your commitment to make these changes?

[ ]  Time

[ ]  Patient Population

[ ]  Training

[ ]  Expense

[ ]  Materials

[ ]  Wrong Approach

[ ]  Not Interested

8. What additional education can (NAME OF ACCREDITED PROVIDER) provide that will assist you in the future?

1. Topic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Topic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Topic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Suggested Speaker(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. What changes, if any, would you like made to your meeting room in future meetings?

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The (NAME OF ACCREDITED PROVIDER) is accredited by the (KENTUCKY MEDICAL ASSOCIATION) to provide quality outcomes-based continuing education to Kentucky physicians and their support staff.

*Please complete the following information if you agree to participate in a post activity questionnaire.*

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suite\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the best way to contact you for the post activity questionnaire?

[ ]  Email [ ]  Mailing Address

**CONTINUING MEDICAL EDUCATION**

 The (name of the accredited provider) is accredited by the Kentucky Medical Association to provide continuing medical

 education for physicians.

 The (name of the accredited provider) designates this (learning format) activity for a maximum of (# of credits) *AMA PRA*

 *Category1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.