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:

_____

_____

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 _____

PLEASE TURN OVER TO COMPLETE

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?

_____

_____

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

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of (name of the accredited provider) and (name of non-accredited provider). 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 Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.