University of Florida Continuing Medical Education

EVALUATION FORM

Program Title: ____________________________________________

Date: ___________________________________________________

Your comments are very important to us! Please complete this evaluation so that we may provide more quality programs in the future.

Expected Clinical Outcomes
1. Will information gained from this program result in enhancing optimal patient care? □ Yes □ No

2. If yes, please list change(s) you intend to make in your practice as a result of this program.

3. Please rate your confidence in implementing these changes.
   □ High confidence □ Moderate confidence □ Low/No confidence □ N/A

4. Please identify any barriers you perceive in implementing these changes (select all that apply)
   □ Cost □ Insurance/reimbursement issues
   □ Lack of time to assess/counsel patients □ Patient compliance issues
   □ Lack of administrative support/resources □ Lack of consensus of professional guidelines

5. How will you address these barriers to implement changes in knowledge and behavior?

Basic Program Evaluation

6. The material was presented at an appropriate level. 5 = Excellent / 4 = Good / 3 = Average / 2 = Fair / 1 = Poor

7. I have gained knowledge that will improve patient care. 5 = Excellent / 4 = Good / 3 = Average / 2 = Fair / 1 = Poor

8. The program met my expectations in accomplishing the stated educational objectives. 5 = Excellent / 4 = Good / 3 = Average / 2 = Fair / 1 = Poor

9. The program content was objective, balanced, and free from commercial bias or influence. 5 = Excellent / 4 = Good / 3 = Average / 2 = Fair / 1 = Poor

10. Your overall rating of the quality of the education offered at this program. 5 = Excellent / 4 = Good / 3 = Average / 2 = Fair / 1 = Poor

11. Additional Comments/Explanations:

12. How can this program be improved? (Please list both strengths and weaknesses.)

13. Based on your educational needs, please provide us with suggestions for future program topics and formats:

Please complete and return this form before 5pm the day of the presentation in order to receive CME credit

Name (Please Print): __________________________ UF ID: __________________________

Please Circle: MD  PhD  ARNP  RN  PA  Division: __________________________

License #: __________________________

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02/Thank you for your feedback!