Title of Session:

Date:

Location:

Presenters:

 **Yes No Unsure** **Comments:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Were you engaged by the quality of the presentation?
 |  |  |  |  |
| 1. Overall did you feel that the presentation(s) met the stated learning objectives?
 |  |  |  |  |
| 1. Were potential conflicts of interest disclosed?
 |  |  |  |  |
| 1. Did you feel you had adequate opportunity to discuss/ask questions?
 |  |  |  |  |
| 1. Was the educational content free of commercial bias?
 |  |  |  |  |
| 1. Will the information provided contribute to the care of your patients?
 |  |  |  |  |
| 1. Did the program have an impact on your practice or performance?
 |  |  |  |  |

1. What barriers do you anticipate that might prevent you from applying what you’ve learned?

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1. What might help you overcome these barriers?

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1. What future educational topics would support your practice?

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Please rate the presentation(s) with regards to clarity, content, relevance and credibility:

**1 = Poor** to **5 = Excellent**

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| --- |
| **SPEAKER #1** |
| effectiveness/clarity | 1 | 2 | 3 | 4 | 5 |
| content relevance | 1 | 2 | 3 | 4 | 5 |
| presenter’s knowledge and credibility | 1 | 2 | 3 | 4 | 5 |
|  |  |  |  |  |  |
| **SPEAKER #2** |
| effectiveness/clarity | 1 | 2 | 3 | 4 | 5 |
| content relevance | 1 | 2 | 3 | 4 | 5 |
| presenter’s knowledge and credibility | 1 | 2 | 3 | 4 | 5 |
|  |  |  |  |  |  |
| **SPEAKER #3** |
| effectiveness/clarity | 1 | 2 | 3 | 4 | 5 |
| content relevance | 1 | 2 | 3 | 4 | 5 |
| knowledge and credibility | 1 | 2 | 3 | 4 | 5 |

Additional comments/feedback:

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