SUNY DOWNSTATE Medical Center | Office of Continuing Medical Education

CONFERENCE/SYMPOSIUM EVALUATION FORM

Thank you for participating in this CME activity. The Office of Continuing Medical Education would like to know if this was a valuable learning experience for you, and would appreciate your responses to the following questions.

Title of Activity _____ **Date**_____

1. Presenter: __	**1=Poor**	**2=Below Average**	**3=Average**	**4=Above Average**	**5=Outstanding**
To what extent was the presenter knowledgeable, organized and effective in his/her presentation?	1	2	3	4	5
Presenter: __					
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Presenter: __					
To what extent was the presenter knowledgeable, organized and effective in his/her presentation?	1	2	3	4	5

2. Indicate the reason you came to the meeting:	Please check all that applied
to develop clinical skills	☐
to develop interpretive and diagnostic skills	☐
to acquire new information on the subject	☐
to review the subject	☐
to meet CME requirements	☐

3. How might the format of this activity be improved in order to be most appropriate for the content presented? select all that apply

Format was appropriate; no changes needed	☐	Add a hands-on instructional component	☐
Include more case-based presentations	☐	Schedule more time for Q and A	☐
Increase interactivity with attendees	☐	Other, describe	☐
Add breakouts for subtopics	☐		

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4. Please rate the overall aspects of this educational activity on the basis of:

	1=Poor	2=Below Average	3=Average	4=Above	5=Outstanding
Educational content	1	2	3	4	5
Relevance to practice	1	2	3	4	5
Questions and discussions	1	2	3	4	5
Oral presentations	1	2	3	4	5
Quality of presenters	1	2	3	4	5
Selection of topics	1	2	3	4	5
Overall quality of activity	1	2	3	4	5

5. Did you have the opportunity to discuss practice-relevant issues with the speakers?

YES ☐	NO ☐

6. How will you change your practice as a result of attending this activity? Select all that apply

☐ Create/revise protocols, policies, and/or procedures	☐ This activity validated my current practice
☐ Change the management and/or treatment of my patients	☐ I will not make any changes to my practice

☐ Other, please specify:

7. Any perceived barriers in making changes identified?	YES ☐	NO ☐

If yes, please indicate:

8. Has this activity met your identified needs and professional practice gaps?	YES ☐	NO ☐

9. Please rate the overall impact of this activity objectives on:

	Not Applicable	No Impact	Moderate Impact	High Impact
Knowledge	☐	☐	☐	☐
Competence	☐	☐	☐	☐
Performance	☐	☐	☐	☐
Patient outcomes	☐	☐	☐	☐

10. Was there any apparent conflict of interest shown by the speaker(s)? If yes, please explain below:	YES ☐	NO ☐

10. How did you obtain information on this program? <u>Circle</u>	Online	Email	Mailed brochure	Word of mouth	Other
11. What influenced you to attend this meeting?	Course description	List of faculty	List of topics	Fee	Host site

12. Based on your needs, provide suggestions for future program topics/formats:

General Comments:

E-mail address to participate in an outcome-measured post evaluation activity:

Specialty :	☐ MD/DO	☐ NP/RN	☐ PA	☐ Student	☐ Other health professional