**POST ACTIVITY EVALUATION**

Name of Activity

Date of Activity

1. **How would you rate the overall quality of this activity?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Excellent** | **Good** | **Fair** | **Poor** |
| [ ]  | [ ]  | [ ]  | [ ]  |

1. **Please rate the impact of the following course objectives.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *As a result of attending this activity, I am better able to:* | **Strongly Agree** | **Agree** | **Disagree** | **Strongly Disagree** |
| Learning Objective #1 | [ ]  | [ ]  | [ ]  | [ ]  |
| Learning Objective #2 | [ ]  | [ ]  | [ ]  | [ ]  |
| Learning Objective #3 | [ ]  | [ ]  | [ ]  | [ ]  |

1. **Please rate the projected impact of this activity on your knowledge, competence, performance and patient outcomes.**

\* Competence is defined as the ability to apply knowledge, skills, and judgment in practice (knowing how to do something)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **No Change** |
| This activity increased my knowledge. | [ ]  | [ ]  | [ ]  |
| This activity increased my competence. | [ ]  | [ ]  | [ ]  |
| This activity improved/will improve my performance. | [ ]  | [ ]  | [ ]  |
| This activity will improve my patient outcomes. | [ ]  | [ ]  | [ ]  |

If you answered 'yes' to any of the items above, please describe:

|  |
| --- |
|  |

1. **Please rate the following speakers on their knowledge/content.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Excellent** | **Above Average** | **Average** | **Below Average** | **Poor** |
| ***Presentation Title #1,* Speaker #1** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Comments: |
| ***Presentation Title #2,* Speaker #2** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Comments: |
| ***Presentation Title #3,* Speaker #3** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Comments: |

1. **Do you feel this activity was free of commercial bias or influence?**

\*Commercial bias is defined as a personal judgment in favor of a specific product or service of a commercial interest.

[ ]  Yes

[ ]  No

If no, please explain.

|  |
| --- |
|  |

1. **Do you feel this activity was evidence-based?**

[ ]  Yes

[ ]  No

If no, please explain.

|  |
| --- |
|  |

1. **Do you plan to make any changes to your practice as a result of attending this activity?**

[ ]  Yes

[ ]  No

[ ]  N/A (I do not work with patients)

Please explain with examples.

|  |
| --- |
|  |

1. **Please indicate any perceived barriers to implementing these changes.** Select all that apply.

[ ]  Cost

[ ]  Lack of knowledge

[ ]  Lack of time to assess/counsel patients

[ ]  Reimbursement/Insurance issues

[ ]  Patient compliance issues

[ ]  Lack of administrative support/resources

[ ]  Lack of consensus or professional guidelines

[ ]  No barriers

[ ]  Other, please specify

|  |
| --- |
|  |

1. **Please list suggestions you have for future topics based on questions you have encountered in your practice, or ideas for future educational activities.**

|  |
| --- |
|  |

1. **Additional Feedback/Comments:**

|  |
| --- |
|  |