**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.

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| --- |
|  |

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

Yes

No

If no, please explain.

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|  |

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.

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|  |

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

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| --- |
|  |

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

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1. **Additional Feedback/Comments:**

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