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| --- | --- |
| Name of RSS Activity |  |
| Title of Presentation |  |
| Date of Presentation |  |

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 |  |  |  |  |

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)

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| --- | --- | --- | --- |
|  | **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:

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1. **Please rate the speaker on knowledge/content of the presentation.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Comments:** | **Excellent** | **Above Average** | **Average** | **Below Average** | **Poor** |

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, please explain:

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

Yes

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)

If yes, please explain with examples. If no, please indicate any perceived barriers to implementing changes.

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1. **Please list suggestions you have for future topics as well as any additional comments.**

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