**Westchester Academy of Medicine**

Office of Continuing Medical Education

333 Westchester Ave., Suite LN01 Telephone: 914-967-9100

White Plains, NY 10604

**CME ACTIVITY EVALUATION FORM**

**Name of Organization**:

**Title of CME Activity**:

**Date of Activity:**

**Evaluation was completed by Physician (MD/DO) Non-Physician (NP/RN/PA/Other)**

**Please rate the speakers on the following: E**xcellent **G**ood **F**air **P**oor

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Presentation Content** | **Presentation style** | **Instructional methods/tools** | | **Environment, acoustics, lighting, AV equipment** |
| Speaker:  Program Title: | E G F P | E G F P | E G F P | E G F P | |

1. **Were verbal or written Faculty Disclosures made? Yes\_\_\_ No\_\_\_**
2. **Do you feel the activity was scientifically sound and free of commercial bias\* or influence?  Yes  No, please explain:** *\*Commercial bias is defined as a personal judgment in favor of a specific product or service of a commercial interest.*
3. **Please rate the impact of the following objectives:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *As a result of attending this activity, I am better able to:* | **Strongly Disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly Agree** |
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1. **Please rate the projected impact of this activity on your knowledge of the subject:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **No Change** | **If yes, please describe:** |
| This activity increased my knowledge. |  |  |  |  |

*\*The Accreditation Council for CME requires us to analyze changes in learners’ competence, performance, or patient outcomes.*

1. **Please identify how you will change your practice as a result of attending this activity (select all that apply).**

This activity validated my current practice; no changes will be made

Create/revise protocols, policies, and/or procedures

Change the management and/or treatment of my patients

Other, please specify:

1. **Based on your participation today, please indicate any barriers, if any, you perceive in implementing strategies or skills taught.**

No barriers

Cost

Lack of experience

Lack of opportunity (patients)

Lack of resources (equipment)

Lack of administrative support

Lack of time to assess/counsel patients

Reimbursement/insurance issues

Patient compliance issues

1. **Will you attempt to address these barriers in order to implement changes in your competence, performance, and/or patients’ outcomes?**

N/A

No – Why not?

Yes – How?

1. **The content of this activity matched my current (or potential) scope of practice.**  **Yes**  **No, please explain:**
2. **How might the format of this activity be improved 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:

1. **The content covered will improve my following core competencies: (check all that apply):**

Patient care or patient-centered care  Interpersonal & commications skills

Practice Based learning & Improvement  Medical Knowledge

Professionalism  Life Long-Learning Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Overall, were the speaker(s) knowledgeable regarding the content?** Yes  No, please specify:
2. **Overall, were the presentations balanced, objective, and scientifically rigorous?**  Yes  No, please explain: \_\_\_\_\_
3. **Was there an opportunity to discuss practice-relevant issues with the speakers?**  Yes  No, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments and suggestions for future programs:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name/Title:**

**(Optional):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank You For Assisting Us In Evaluating This Program**