**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** |
|  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

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**