POST CME PROGRAM EVALUATION FORM

Activity: 
Speaker: 
Date: 
Honorarium: Yes _______ No _______
Evaluation was completed by: Physician ________ Non-Physician__________

Please rate the speaker on the following areas: Excellent (E) Good (G) Fair (F) Poor (P)

<table>
<thead>
<tr>
<th>Presentation Content</th>
<th>Presentation Style</th>
<th>Instructional Methods/tools</th>
<th>Environment, Acoustics, Lighting, AV Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>E G F P</td>
<td>E G F P</td>
<td>E G F P</td>
<td>E G F P</td>
</tr>
</tbody>
</table>

The stated objectives of this program were: Exceeded_____ Met_____ Not Met_____

Objectives Listed Here

Did the content covered improve the following competencies? (Check all that apply)

___ Patient Care
___ Practice-based learning and improvement
___ Interpersonal communication skills
___ Professionalism
___ System-based practice
___ Medical Knowledge

Did the content meet your needs and expectations? Yes____ No____ If you answer yes, please specify _____________________________________________________________

Will the knowledge gained today affect your practice?

Very much______ Moderately _____Minimally _____None____

TO RECEIVE CME CREDITS – YOU MUST COMPLETE AND ANSWER ALL QUESTIONS

BEFORE THE PRESENTATION ANSWER THE FOLLOWING QUESTIONS

1) How do you evaluate and treat (problem X) now?

________________________________________________________________

________________________________________________________________

AFTER THE PRESENTATION ANSWER THE FOLLOWING QUESTIONS

1) After attending this presentation how would you initially evaluate and treat the (problem)?

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________
*Based on your participation today, have you identified any barriers when implementing new information or techniques learned in this presentation? Please √ all that applies

____ Cost
____ Lack of experience
____ Lack of resources
____ Lack of time to assess/counsel patients’
____ No Barriers
____ Technical Skills
____ Lack of consensus or professional guidelines
____ Reimbursement/Insurance Issues
____ Patient compliance issues
____ If Other – please specify________________

YOU MUST ANSWER THE QUESTIONS AND SPECIFY HOW THIS COURSE CHANGED YOUR

. Medical Knowledge
HOW: ____________________________________________

. Awareness of Practice Trends
HOW: ____________________________________________

. Practice Skills
HOW: ____________________________________________

. Professional Competencies
HOW: ____________________________________________

WAS PRESENTATION FREE OF COMMERCIAL BIAS? Yes No

WERE VERBAL OR WRITTEN DISCLOSURES MADE TO THE AUDIENCE PRIOR TO THE PRESENTATION? Yes No

TOPICS FOR FUTURE PROGRAMS

Good Samaritan Hospital is accredited by The Medical Society of the State of New York (MSSNY) to provide Continuing Medical Education for physicians

Good Samaritan Hospital designates this live activity for a Maximum of 1 AMA/PRA Category One Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity

Disclosure Statement

Policies and standards of the Medical Society of the State of New York and the Accreditation Council for Continuing Medical Education require that speakers and planners for continuing medical education activities disclose any relevant financial relationships they may have with commercial interest whose products, devices or services may be discussed in the content of a CME activity

The faculty participants do not have any financial arrangements or affiliations with any commercial entities whose products, research or services may be discussed in these materials. Any discussion of investigational or unlabeled uses of a product will be identified

PARTICIPANT COMPLETING THE FORM SIGN AND DATE

(PLEASE PRINT) NAME: ____________________________________________

DATE: ____________________________

Revised 08/2016