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Event Evaluation

Please complete the following questions and then submit after reviewing your responses. All questions are required. Once you have completed this evaluation you will be able to print your CME certificate.

Determining your CME credit hours;

To determine how many CME hours you have obtained, refer to the attendance worksheet located in the syllabus. This will list how many credits each session is worth and give you a place to calculate how many hours of continuing medical education you attended.

 **Please Note: Speakers can only claim CME credit for the sessions you attended, not the sessions you presented. For information regarding speaker credit for your presentation, contact the American Medical Association,**

Please enter the number of hours you attended. *



Please identify your profession/credit type *

- MDs & DOs – AMA PRA Category 1 Credit™
- PAs – AAPA Category 1 CME Credit
- APRNs – Oklahoma Board of Nursing Pharmacology Hours
- Nursing - ANCC Nursing Credit
- PharmDs – Oklahoma State Board of Pharmacy (OSBP) Contact Hours
- All other healthcare professionals – Non-physician certificate of participation

This Activity was: *

- Entirely within my scope of practice
- Somewhat within my scope of practice
- Not within my scope of practice but will be helpful in the future

When reflecting on this activity, will you make changes in your practice? (please select the best answer.) The Office of Continuing Professional Development is required to determine change in practice based on attendance at CME activities. Changes might include any of the following: patient care, research, understanding of disorders and their treatments, administration, professional practice, business processes or personal improvement.

- Yes, I will make changes in my practice immediately
- No, I will not make any changes
- I am already following recommendations presented and/or information presented is in line with my current practice

NOTE: Please see page 5 for response options if "NO" is selected

Name at least one or more change(s) you will make in your practice: *



Based on the changes listed above, what percentage of your patients per month would be affected by the changes? *

- 5% 10% 15% 20% 25% 30% 35% 40% 45% 50%
- 55% 60% 65% 70% 75% 80% 85% 90% 95% 100%

What competencies did this activity address? (select all that apply) *

- Patient care
 Medical knowledge
 Practice-based learning and improvement
 Interpersonal and communication skills
 Professionalism
 Systems-based practice

When reflecting on the overall conference, please rate whether the stated goals and/or objectives were met.**Overall, this activity contained or achieved:**

Presenters that were qualified and varied experts *

- Yes No Not Applicable

Qualified Moderators *

- Yes No Not Applicable

Course content that was objective, balanced and evidence-based *

- Yes No Not Applicable

Unbiased educational information and materials *

- Yes No Not Applicable

Types of sources of evidence were identified *

- Yes No Not Applicable

New clinical data *

- Yes No Not Applicable

New treatment guidelines *

- Yes No Not Applicable

New medical research *

- Yes No Not Applicable

Information that improved my patient outcomes *

- Yes No Not Applicable

Information that will increase my competence *

- Yes No Not Applicable

Information that will expand my performance *

- Yes No Not Applicable

Healthcare quality improvement information *

- Yes No Not Applicable

Enhancements that will help me improve safety issues for my patients *

- Yes No Not Applicable

An overall quality that met my expectations and personal learning needs *

- Yes No

In this activity, was at least 25% of the time allocated to interactive learning formats?

- Yes No

Thinking about the overall activity, please indicate which educational learning formats were utilized. (Check all that apply) *

- | | |
|--|---|
| <input type="checkbox"/> Didactic Presentation | <input type="checkbox"/> Hands-on Workshop |
| <input type="checkbox"/> Simulation Patient (live) | <input type="checkbox"/> Homework Exercises |
| <input type="checkbox"/> Reading Assignments | <input type="checkbox"/> Demonstration |
| <input type="checkbox"/> Movie/Video | <input type="checkbox"/> Case Discussions |
| <input type="checkbox"/> Work on Simulators/Models (inanimate) | <input type="checkbox"/> Questions and Answer |
| <input type="checkbox"/> Panel Discussion | <input type="checkbox"/> Audience Response System/Online Polling Services |
| <input type="checkbox"/> Small Group Discussion | <input type="checkbox"/> Other, please specify |

If other marked above, please specify:

Disclosure of planners', moderators' and speakers' relevant relationship(s) with commercial and in-kind support was provided. *

- Yes No, please explain

If No, please specify

Discussion of experimental or off-label drugs, therapies and devices was disclosed. *

- Yes No, please explain

If No, please specify

Product-promotion or product-specific advertisements were separate or outside the educational material or meeting space, if applicable. *

- Yes No, please explain Not Applicable

If No, please specify

What do you consider the major benefit from attending this accredited activity? *

What did you perceive as weaknesses of this activity? *

What topics would you like added to the next activity? *

Please rate the MODERATORS:

Ability to keep sessions free from commercial bias *

- Poor Fair Satisfactory Very Good Excellent

Ability to field participants' questions *

- Poor Fair Satisfactory Very Good Excellent

Use of time management *

- Poor Fair Satisfactory Very Good Excellent

Please rate the success of all SPEAKERS in accomplishing the following:

Current Topics *

- Poor Fair Satisfactory Very Good Excellent

Poor Fair Satisfactory Very Good Excellent

Clarity and good organization of material *

Poor Fair Satisfactory Very Good Excellent

Ability to apply content to practice *

Poor Fair Satisfactory Very Good Excellent

Summarized with outcome measures *

Poor Fair Satisfactory Very Good Excellent

Please use this space if you have additional SPEAKER comments.* Your comments are important to us!

Would you recommend this conference to your colleagues? *

- Yes
- No, please explain
- Not Applicable

If No, please explain

Please use this space if you have additional comments: Your comments are important to us!

If the Submit button below (computer) or above (tablet/mobile) is dimmed, you have not fully completed the evaluation. Please review the form for any required fields (with an asterisk) that you may have missed.



If NO is selected:

When reflecting on this activity, will you make changes in your practice? (please select the best answer.) The Office of Continuing Professional Development is required to determine change in practice based on attendance at CME activities. Changes might include any of the following: patient care, research, understanding of disorders and their treatments, administration, professional practice, business processes or personal improvement.

- Yes, I will make changes in my practice immediately
- No, I will not make any changes
- I am already following recommendations presented and/or information presented is in line with my current practice

If you answered that you have not made any changes, please tell us why you haven't and what barriers are preventing you: (Select all that apply) *

- Content presented was not appropriate for my specialty
- I perceive the changes to be detrimental to my patients
- I need more information before making changes
- I will research comments made by presenter(s) for possible change in the future
- No clinical application
- Resource availability (staff, funding)
- Management priorities
- Fundamental delivery system redesign would be necessary
- Time constraints
- Need for more training
- Reimbursement
- I haven't because of the following system/process barriers: (Please identify in the text box)
- I haven't because of the following patient adherence issues: (Please identify in the text box)
- Lack of opportunity with my current patients
- Other, please specify

If other, please specify

If "I am already following recommendations presented and/or information presented is in line with my current practice" is selected: