UND UNIVERSITY OF NORTH DAKOTA GRAND FORKS, ND

School of Medicine & Health Sciences
CME EVALUATION
"Activity Title"
Presenter/Speaker
Date

In accordance with the Accreditation Council for Continuing Medical Education (ACCME) and the UND School of Medicine and Health Sciences CME Policy

None of the Providing Unit, Planners or Presenter for this educational activity have relevant financial relationship (s) to disclosure with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Trade Name (s): NA

Off-Label use: NA

Please fill in marks completely using a pen or pencil Correct: ● Incorrect: ⃠ ⊗

Please rate the following questions for the overall course:

	Excellent	Very Good	Good	Fair	Poor
My overall reaction was	O	O	O	O	O
The clarity and organization of the presentation was	O	O	O	O	O
The speaker's knowledge of the topic was	O	O	O	O	O
Practical application to my practice/research	O	O	O	O	O

How well did this program fulfill the following learning objectives?
Upon completion of this educational activity, the participant should be better able to:

1. Describe…	O	O	O	O	O
2. Discuss…	O	O	O	O	O
3. Identify…	O	O	O	O	O

	Yes	No
Was the presentation free of commercial bias?	O	O

If you feel there has been commercial bias, please explain:

	Expert	Very Knowledgeable	Somewhat Knowledgeable	Slightly Knowledgeable	Novice
How would you rate your level of knowledge about the program content <u>before</u> you attended this program?	O	O	O	O	O
How would you rate your level of knowledge about the program content <u>after</u> you attended this program?	O	O	O	O	O

Please rate the projected impact of this activity on your knowledge, competence, performance, and patient outcomes:

	Yes	No	No Change	If yes, please describe:
This activity increased my knowledge. (knowing what to do)	O	O	O	
This activity increased my competence. (knowing how to do something)	O	O	O	
This activity improved my performance. (ones actual behavior in practice)	O	O	O	

Please complete the other side →

Indicate which of the following professional competency(s) was addressed by this educational activity: (select all that apply)

O Patient-centered care	O Interpersonal & communication skills
O Medical knowledge	O Apply quality improvement
O Work in interdisciplinary teams	O Professionalism
O Practice-based learning & improvement	O Utilize informatics/information technology
O Employ evidence-based practice	O Systems-based practice

Will the information presented cause you to make any changes in your practice/research?	**Yes**	**No**
	O	O

If yes, please describe any change(s) you plan to make:

If yes, how committed are you to making these changes?	**Very Committed**	**Committed**	**Neutral**	**Not Committed**	**Not at All**
	O	O	O	O	O

If no, what barriers may exist to prevent you from making changes? (check all that apply)

O	Clinical application	O	Time constraint
O	Resource Availability (staff, funding)	O	Need for training
O	Management priorities	O	Reimbursement
O	Fundamental delivery system redesign necessary	O	Resistance to change
O	Other		

If Other, please explain:

Do you feel future activities on this subject matter are necessary and/or important to your practice?	**Yes**	**No**
	O	O

Professional Designation:

O MD, DO	O PhD	O PharmD, RPh	O Student
O PA, NP	O RN, LPN	O RT, RRT	O Med Tech
O PT	O OT	O Other: _____	

Please describe any clinical situations that you find difficult to manage or resolve that you would like to see addressed in future educational activities:

Additional comments:

I, _____, certify that I attended the above program and claim ___ hour(s) of credit
(Signature)

Participant Name: _____ Title: _____

Facility/Address: _____

Is this a new mailing address? Yes □ No □

Email Address: _____

Is this a new email address? Yes □ No □

In order to receive credit for this educational activity, please complete and return this evaluation form. Thank you.