**Thank you for your participation in this activity.**

As a follow-up to your learning experience, please answer the questions below. We thank you for your time, and look forward to your responses.

**Please rate your level of agreement with the following statements about the quality of the education provided.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Strongly Agree** | **Agree** | **Disagree** | **Strongly Disagree** |
| Learning objectives were achieved |  |  |  |  |
| Content was evidence-based |  |  |  |  |
| Delivery of content was effective |  |  |  |  |
| Content presented was consistent with the ethical standards of research |  |  |  |  |
| Presentations were engaging |  |  |  |  |
| Content presented was immediately applicable to my practice |  |  |  |  |
| Content presented was the appropriate level of difficulty |  |  |  |  |
| Content presented increased my level of confidence in addressing clinical issues |  |  |  |  |
| My practice and the care of my patients will benefit from my participation in this meeting |  |  |  |  |
| My Overall Rating for this meeting is “Excellent.” |  |  |  |  |
| I would recommend this meeting to my colleagues. |  |  |  |  |

1. Did any of the speakers have commercial bias?

YES  NO

If YES, please provide more detail about the bias observed.

|  |
| --- |
|  |

1. Did the speaker(s) properly disclose financial relationships (name of commercial interest and nature of relationship) or state that they had nothing to disclose?

YES  NO

If NO, please explain.

|  |
| --- |
|  |

1. Was any off-label (investigational/experimental) use discussed?

YES  NO

1. If Yes, was this disclosed to the learners?

YES  NO

If NO, please identify the speaker and explain.

|  |
| --- |
|  |

1. Do you intend to make a change in your practice as a result of the knowledge acquired during this activity?

YES

Please identify a measurable change you will make in your practice.

|  |
| --- |
|  |

NO *(select all that apply)*

I need to seek additional information on this topic.

Barriers prevent me from changing my practice.

Change is not needed; this activity validated my current practice.

Change is not needed; the content presented does not align with my practice beliefs.

The content was not applicable to my clinical practice or the position I hold.

1. Do you anticipate any barriers to making a change in your practice?

YES *(select all that apply)*

Lack of supporting evidence in the literature

Do not have an implementation strategy

Lack of staff time to implement change

Lack of equipment or necessary resources

Insurance reimbursement issue

Organizational/Institutional culture

Patient adherence issues

NO *(select all that apply)*

I do not anticipate encountering any barriers to my intended change.

Change is not needed; this activity validated my current practice.

Change is not needed; the content presented does not align with my practice beliefs.

Not applicable to my practice

1. Based on educational needs, please provide healthcare of professional gaps that should be addressed in future educational activities and that may be applicable to your practice.

|  |
| --- |
|  |

1. Please describe any ways we might improve this educational activity.

|  |
| --- |
|  |

1. Was there any speaker that stood out as exceptional?

|  |
| --- |
|  |

1. Was there any speaker that may need some improvement?

|  |
| --- |
|  |

1. Additional Comments

|  |
| --- |
|  |

1. Please indicate your professional title

MD/DO

PharmD

PhD

RN

NP

PA

Other

1. How many years have you been in practice?

0-5 years

6-10 years

11-15 years

More than 15 years

1. How many patients do you manage weekly?

0-25

26-50

51-75

76-100

More than 100