

BC Transplant Education Days 2018- Evaluation Feedback

Transplant Day

Please provide us your feedback, which will help us to plan future educational events. Your response will be kept anonymous.

Physician Resident other (Please specify) _____
 RN (specify area of practice) _____
 RT
 Pharmacist/Pharmacy Technician
 Allied Health (please specify) _____
 Health authority employed _____

INSTRUCTIONS: Please circle the number that reflects your assessment of each of the following:

PART A – LEARNING & APPLICATION OF KNOWLEDGE

1 = minimally 5 = greatly

- | | | | | | |
|--|---|---|---|---|---|
| 1. Did the program meet your overall learning needs? | 1 | 2 | 3 | 4 | 5 |
| 2. The information I learned will be applied to my practice. | 1 | 2 | 3 | 4 | 5 |

PART B: SESSION EVALUATIONS

1. Did you perceive any bias, whether industry or other, in any part of the program?
 Yes _____ No _____

2. What was the most *effective* part of the program? Why?

3. What was the least *effective* part of this program? Why?

4. How could this program be improved?

5. Please list *Topics* and *Speakers* for future programs:

Additional comments or suggestions:

PART C – PROGRAM OVERALL

1 = Unsatisfactory 3 = Satisfactory 5 = Exceptional

- | | | | | | |
|---|-----|----|-----|-----|---|
| 1. FORMAT: Lectures, discussions, audience size, etc. | 1 | 2 | 3 | 4 | 5 |
| 2. CONTENT: Relevance to my job | 1 | 2 | 3 | 4 | 5 |
| 3. CONTENT: Compatibility with my expectations | 1 | 2 | 3 | 4 | 5 |
| 4. INTERACTIVITY: Adequate opportunities for interaction | 1 | 2 | 3 | 4 | 5 |
| 5. COMMUNICATION: Did you receive timely information about event | 1 | 2 | 3 | 4 | 5 |
| 6. REGISTRATION: Did you have difficulty registering? | ___ | No | ___ | Yes | |
| 7. OVERALL RATING OF THIS PROGRAM | 1 | 2 | 3 | 4 | 5 |

Comments:

Thank you for completing the evaluation. Please return this to the session facilitator or the registration desk at the end of the program.

NOTE: If you'd like to apply to CME credits for the sessions you attended, please complete this form. Please return both forms separately.

CME Request Form

(Submit separately from evaluation feedback form)

Please check off which BC Transplant Education Day(s) you attended.

Sept 24 (Donation) All day _____ Half day _____

Sept 25 (Transplant) All day _____ Half day _____

Name: (please print) _____

Phone: _____

Email: _____

Thank you for attending the BC Transplant Education Days. You will receive an email shortly with your UBC Accredited CME credit certificate.