**ATTACHED IS AN EVALUATION SUMMARY FORM FOR COMPLETION AFTER YOUR SERIES IS COMPLETED (FOLLOW YOUR APPLICATION-CALENDAR YEAR OR ACADEMIC YEAR).**

**PLEASE TOTAL THE EVALUATION SUMMARY FORMS FROM EACH SESSION OF THE SERIES AND TALLY BY:**

**-All Physicians (Including all Residents)**

* **COMPLETE ALL SHADED AREAS.**
* **INCLUDE ALL COMMENTS UNDER QUESTION # 8 REGARDING CHANGES IN PARCTICE.**

**PLEASE COMPLETE ALL SHADED AREAS**

OFFICE OF CONTINUING EDUCATION

STONY BROOK SCHOOL OF MEDICINE/HEALTH SCIENCES CENTER

STATE UNIVERSITY OF NEW YORK AT STONY BROOK

***EVALUATION SUMMARY FORM-FULL SERIES***

|  |  |
| --- | --- |
| **EVALUATION OF PROGRAM:** |  |
| **SERIES TIMEFRAME:** |       |
| **Total # All Physicians (Including all Residents)** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Very Well** | **Adequately** | **Poorly** | **No Response** |
| 1. | The program addresses problems I face in my practice |       |       |       |       |
| 2. | This program met its objective |       |       |       |       |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Excellent** | **Very Good** | **Good** | **Fair**  | **Poor** | **No Response** |
| 3. | The presentation was |       |       |       |       |       |       |
| 4. | The discussion was |       |       |       |       |       |       |
| 5. | The illustrative/audio visual materials were |       |       |       |       |       |       |

6. Presentation was free of commercial bias (if no, specify):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| a. |       | Yes |       | No response |
| b. |       | **NO**, *If no, commercial bias indicated by* |
|  |       | Unbalanced view of therapeutic options |
|  |       | Failure to use generic names |
|  |       | Use of single brand name vs. several |
|  |       | Illustrative material (e.g. audio-visual) reflects company product promotion |
|  |       | Failure to disclose that product recommended for off label use or still investigational |
|  |       | Other/specify:       |

7. THIS PROGRAM: (*please check all that apply*)

|  |  |  |  |
| --- | --- | --- | --- |
|       | Will alter my practice performance. |       | Will result in better patient outcomes. |
|       | Won't alter my performance, but convinced me I'm doing the right thing. |       | Did not satisfy my expectation. |
|       | Will be relevant to my practice. |       | Satisfied my expectation. |
|       | Will not be relevant to my practice. |  |  |

8. Will you make any changes in practice as a result of this CME activity?       **YES**       **NO**

 If yes, please describe a specific change you will make:

9. The content covered will improve my following competencies: (check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
|       | Patient care. |       | Interpersonal communication skills. |
|       | Medical knowledge |       | Professionalism. |
|       | Practice-based learning and Improvement |       | Systems-based practice. |