

{Provider}

Presentation Title:
Date:
OBN-010-93-

PRESENTATION EVALUATION FORM

Please provide the following information - Thank you!

Name & Contact Information (*optional*) _____

What would improve future presentations? _____

What did you like best about today's presentation? _____

What information would you like to see at future presentations? _____

How did you hear about this presentation? _____

Other Comments: _____

Were the facilities conducive to learning: (Circle one): YES NO

1 = No 2 = Slightly 3 = Somewhat 4 = Yes 5 = Yes - significantly

Please evaluate the program according to the above rating scale by circling the number that applies

Overall Program:

The outcomes were met as stated.	1	2	3	4	5
The presentation met my expectations.	1	2	3	4	5
The presentation will improve my practice and patient care.	1	2	3	4	5
I will attend future programs offered by the sponsor.	1	2	3	4	5
I would recommend this training program to others.	1	2	3	4	5

Presenter: {name}

Teaching effectiveness	1	2	3	4	5
The presenter was knowledgeable about materials covered.	1	2	3	4	5
The presenter answered questions effectively.	1	2	3	4	5
Method of presentation (power points, lecture, activities etc.)	1	2	3	4	5
Did you perceive commercial bias during this presentation (Circle one):	YES		NO		

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