Your comments are very important to us!
Please complete this evaluation so that we may provide more quality programs in the future.

Expected Clinical Outcomes
1. Will information gained from this program result in enhancing optimal patient care?  ☐ Yes  ☐ No
2. If yes, please list change(s) you intend to make in your practice as a result of this program.
3. Please rate your confidence in implementing these changes.
   ☐ High confidence  ☐ Moderate confidence  ☐ Low/No confidence  ☐ N/A
4. Please identify any barriers you perceive in implementing these changes (select all that apply)
   ☐ Cost
   ☐ Insurance/reimbursement issues
   ☐ Lack of time to assess/counsel patients
   ☐ Patient compliance issues
   ☐ Lack of administrative support/resources
   ☐ Lack of consensus of professional guidelines
5. How will you address these barriers to implement changes in knowledge and behavior?

Basic Program Evaluation
5 = Excellent / 4 = Good / 3 = Average / 2 = Fair / 1 = Poor
6. The material was presented at an appropriate level.  5 4 3 2 1
7. I have gained knowledge that will improve patient care.  5 4 3 2 1
8. The program met my expectations in accomplishing the stated educational objectives.  5 4 3 2 1
9. Your overall rating of the quality of the education offered at this program.  5 4 3 2 1
10. Additional Comments/Explanations:
11. How can this program be improved? (Please list both strengths and weaknesses.)
12. Based on your educational needs, please provide us with suggestions for future program topics and formats:

Thank you for your feedback!

5/2014
University of Florida Continuing Medical Education
University of Florida, Department of Psychiatry Grand Rounds

EVALUATION FORM
Section #4140 FRC WEB

Program: 
Date: 
Speaker: 

Fill this form out completely for a RECORD of your attendance to this lecture

______________________________
Full Name (PRINTED)

______________________________
UF ID Number

______________________________
State License Number

Please Circle or Write your Title (ALL THAT APPLY)
M.D. Ph.D. LCSW LMHC LMFT ARNP

Medical Student Resident

Fellow Psy.D. Faculty Other: ________________

Please complete and return this form before 5pm the day of the presentation to:

Attn: Debra Krawczykiewicz debra@ufl.edu or 352-392-9887 (fax)