SCHOOL OF MEDICINE
CONTINUING MEDICAL EDUCATION & PROFESSIONAL DEVELOPMENT

Learning & Feedback Form

ACTIVITY: ______________________________ DATE: ________________

PRESENTATION TITLE: ______________________________

PRESENTER: ______________________________

YOUR TITLE: PHYSICIAN PA NP CNM OTHER ______________________

Session title:

Information from this activity will be incorporated into my medical practice.

___ Strongly Disagree ____Disagree ____Neutral ____Somewhat Agree ____Strongly Agree

Changes in my practice that I am going to make:

1. ______________________________
2. ______________________________

If no changes, why not?

1. ______________________________
2. ______________________________

Delivered balanced and objective, evidence-based content?

___ Strongly Disagree ____Disagree ____Neutral ____Somewhat Agree ____Strongly Agree

Did you feel this presentation conveyed any commercial bias? Yes_____ No_____

COMMENTS: ______________________________

Please rate the effectiveness of the speaker:

___ Not Effective ____Somewhat Effective ____Moderately Effective ____Very Effective ____Extremely Effective

COMMENTS:______________________________

Please list topics of interest to you for future activities:

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