

**CHILDRENS HOSPITAL - PEDIATRIC GRAND ROUNDS -- PODCAST
EVALUATION FOR ALL ATTENDEES**

DATE: _____

Print NAME CLEARLY: _____

Your signature indicates listening to the entire program

Address: _____

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MD LICENSE # _____

Staff Physician Resident Physician Other _____

Presentation Title: _____

ME Presentation Code: _____

**"Children's Hospital is accredited by the
Nebraska Medical Association Commission on
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maximum of 1 hour category
1 credit toward the AMA Physician's
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Each physician should claim only those
credits that he/she
actually spent in the activity."**

PLEASE FAX THIS COMPLETED FORM TO:

Continuing Medical Education
Childrens' Memorial Hospital
(402) 955-4162

Effectiveness of Presentation:

	Excellent			Poor	
Speaker #1	5	4	3	2	1
Speaker #2	5	4	3	2	1

	Agree			Disagree	
Program content is relative to my practice:	5	4	3	2	1
Program met learning objectives:	5	4	3	2	1
The teaching method was effective:	5	4	3	2	1

	Agree			Disagree	
I gained information that will be useful in the care of my patients:	5	4	3	2	1
I gained skills that will be useful in the care of patients or my activity as a physician:	5	4	3	2	1

How has this program improved my fund of knowledge?

How will this presentation benefit you in the treatment of your patient? _____

List your most interesting or challenging patient care or medical practice issue this week: _____

Other Comments: _____

How did you listen to this Grand Rounds? ____ Podcast _____ Streaming video ____ Satellite

Requested future topics/presenters?

We contact participants periodically for quality assurance. May we contact you? ____ Yes ____ No

Thank you for taking the time to complete and return this form. The compilation of this information is essential for effective future program planning.