

**Appropriate VTE Prevention and Treatment:
Delivering Quality Care From the Inpatient to the Outpatient Setting**

SCEPTER™ values your opinions in helping us further our commitment to excellence in our educational programs. **NOTE:** a CME certificate is issued only upon receipt of your completed evaluation form. We will be sending you an additional questionnaire in approximately 2 months to help determine the enduring value and improve our programs.

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING OR CHECKING THE APPROPRIATE RATING:

	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
1) Overall, how satisfied are you with this program.	1	2	3	4	5
2) Please indicate how you feel about the following statements concerning this program:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. The program met the stated educational objectives.	1	2	3	4	5
Upon completion of the program, participants will be able to:					
• Identify hospitalized patients who are at risk for venous thromboembolic events	1	2	3	4	5
• Describe appropriate VTE prophylaxis and treatment based on current evidence-based recommendations	1	2	3	4	5
• Review JCAHO standards concerning VTE management and assess their clinical applications	1	2	3	4	5
b. The information presented in this activity was pertinent to my professional needs	1	2	3	4	5
c. The teaching and learning methods were effective	1	2	3	4	5
d. The learning assessment used for this activity was appropriate	1	2	3	4	5
e. The information was presented in a fair and balanced manner and examined the topic with scientific rigor.	1	2	3	4	5

3) I would recommend this program to a colleague. Yes No
a. Why / Why not recommend this program?

4) This program was free of commercial bias. Yes No
a. If no, please describe the bias:

5) Please rate the faculty using the following scale: 1 = Poor 2 = Fair 3 = Average 4 = Good 5 = Excellent

Faculty Name	Knowledge of Subject Matter					Effectiveness of Delivery				
David A. Garcia, MD	1	2	3	4	5	1	2	3	4	5
Stephan Moll, MD	1	2	3	4	5	1	2	3	4	5

COMMENTS

1) Is there any ONE thing that you learned at this program which you can apply, in the next six months that will affect your patient's health care outcomes?
 Yes No Not Applicable

a. Please explain:

2) How would you improve this program?

3) What topics, speakers, etc. would you like to see in future programs?

DEMOGRAPHICS

1) What is your primary profession? (Please choose the one area that best fits you.)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> RN | <input type="checkbox"/> LPN/LVN |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Administrative (non-clinician) | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Other: _____ |

2) What is your primary specialty? (Please choose the one area that best fits you.)

- | | | | |
|---|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Hospitalist | <input type="checkbox"/> Hematology | <input type="checkbox"/> Internists | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> Orthopedic surgery | <input type="checkbox"/> Intensivists | <input type="checkbox"/> Primary Care | <input type="checkbox"/> Other: _____ |

3) How did you first learn about this program?

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Brochure | <input type="checkbox"/> Telephone Reservations Center | <input type="checkbox"/> Advertisement | <input type="checkbox"/> Colleague |
| <input type="checkbox"/> Website / internet | <input type="checkbox"/> Fax | <input type="checkbox"/> E-Mail | <input type="checkbox"/> Other: _____ |

4) Please check the top three (3) reasons why you decided to participate in this activity?

- | | | |
|--|---|--|
| <input type="checkbox"/> Quality of speakers | <input type="checkbox"/> Apparent value for expense | <input type="checkbox"/> Convenience of format |
| <input type="checkbox"/> Needed credits | <input type="checkbox"/> Topics | <input type="checkbox"/> Other: _____ |

ADDITIONAL INFORMATION

Future Programs

Yes, SCEPTER has my permission to fax and/or e-mail information to me about future CE activities.

To better define and meet the CME needs of health care professionals and enhance future CME activities, SCEPTER will conduct an outcomes measurement survey following the conclusion of the program. This follow-up survey is designed to measure changes to attendees' practice behaviors that are a result of their participation in this CME activity. We greatly appreciate your participation.

CONTACT INFORMATION

NOTE: we require completion of this information in order to receive credit for participation in this educational activity

Name: _____ Degree: MD DO PharmD RPh NP RN PA Other _____

Specialty: _____ Profession (eg, physician, pharmacist, nurse): _____

Affiliation: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ E-mail: _____

Please check one

- Pharmacist:** To receive a maximum of 1.0 ACPE Credit
- Physician:** To receive a maximum of 1.0 *AMA PRA Category 1 Credit*TM
- Nurse:** To receive a maximum of 1.0 ANCC Credit
- Other:** To receive a certificate of completion for a maximum of 1.0 hour of continuing education

I certify my actual time spent to complete this educational activity to be _____ hour(s). (Maximum of 1.0 hour)

Signature _____ Date _____

OBTAINING CREDIT

Please give the completed evaluation form to the on-site program coordinator. You may also mail the completed form to the address listed below.

SCEPTER

Attn: Sharine Newby

8 Skyline Drive

Hawthorne, New York 10532

Healthcare professionals will receive a CE certificate via US Mail within 3-4 weeks upon receipt of the completed evaluation form.

SCEPTERTM
Thank you for your participation.