SCEPTER™ | CONTINUING MEDICAL EDUCATION EVALUATION FORM

Implementing Recommendations for HIV Management in the Primary Care 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

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
2)	Please indicate how you feel about the following statements concerning this program:					
a)	The program met the stated educational objectives.	1	2	3	4	5
	Upon completion of the program, participants will be able to:					
	• Identify high-risk behaviors that may impact the screening and early diagnosis of HIV in military veterans of the United States	1	2	3	4	5
	• Describe current guideline recommendations for diagnosis and initial treatment of HIV	1	2	3	4	5
	• Identify initial HIV treatment with regard to clinical practice of the military health care provider, consistent with current Veterans Affairs drug use guidelines	1	2	3	4	5
b)	The information provided in this program will ultimately benefit patient care.	1	2	3	4	5
c)	The information presented in this activity was pertinent to my professional needs	1	2	3	4	5
d)	The program was well organized	1	2	3	4	5
e)	The teaching and learning methods were effective	1	2	3	4	5
f)	The learning assessment used for this activity was appropriate	1	2	3	4	5
g)	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. 1 Yes 2 No

a) Why / Why not recommend this program?

____

____

4) This program was free of commercial bias. 1 Yes 2 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**				
• Philip Keiser, MD	1	2	3	4	5	1	2	3	4	5
• Naiel N. Nassar, MD	1	2	3	4	5	1	2	3	4	5

Demographics

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

- o Physician
- o Physician's Assistant
- o Pharmacist
- o Administrative (non-clinician)
- o Nurse Practitioner
- o LPN/LVN
- o RN
- Other: ____________________

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

- o Primary Care
- o Family Medicine
- o Infectious Disease
- o Hospitalist
- o Emergency Room
- Other: ____________________

3) How many years have you been active in your primary profession? ___________________

4) How did you first learn about this program?

- o Brochure
- o Website / internet
- o Telephone Reservations Center
- o Advertisement
- o Fax
- o Other
- o Colleague
- o E-Mail

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

_____ Quality of speakers
_____ Needed credits
_____ Convenience of format
_____ Apparent value for expense
_____ Topics
_____ Other

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 healthcare outcomes?

o Yes o No o 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?

____

____

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 (if other than degree):**	
Affiliation:		
Street:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	**E-mail:**

Please check one
□ **Physician:** To receive a maximum of 1.0 *AMA PRA Category 1 Credit™*
□ **Registered Nurse:** To receive a maximum of 1.0 ANCC Credit
□ **Pharmacist:** To receive a maximum of 1.0 (0.1 CEU) ACPE Credit

Thank you for your participation.