CHICAGO MEDICAL SCHOOL

ROSALIND FRANKLIN UNIVERSITY *of* MEDICINE AND SCIENCE

NAME OF THE JOINT SPONSOR

Title of the Activity

Date of the Program

Location

CME ATTENDANCE RECORD & ACTIVITY EVALUATION

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Rosalind Franklin University of Medicine and Science and the **Name of the Joint Provider**. Rosalind Franklin University of Medicine and Science is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide Continuing Medical Education for physicians. Rosalind Franklin University of Medicine and Science designates this live activity for a maximum of **00.0** ***AMA PRA Category 1 Credit(s)™.*** Physician should claim only the credit commensurate with the extent of their participation in the activity.

1. How well were the objectives of this activity met?

Objectives ***As a result of this course, the participant will be able to:***	**Not at all met**	**Some what met**	**Mostly met**	**Fully met**
Enter the Objective				
Enter the Objective				
Enter the Objective				
Enter the Objective				
Enter the Objective				
Enter the Objective				
Enter the Objective				

2. How would you rate the outcome of this activity? ***1*** *is the* ***lowest;*** ***4*** *is the* ***highest***

Outcome (Elements)	**1** (Little or none)	**2**	**3**	**4** (High)
Provided me with new patient care and/or performance strategies.				
Will influence how I care for patients in my practice.				
Provided information which may improve performance and/or patient outcomes.				
Provided me with new knowledge regarding basic science of problem.				
Provided me with new insights into education, professionalism, or healthcare delivery and funding.				

3. How would you rate the presentation(s) of the speaker(s) for this activity?

Date

Name of the Speaker(s)	**Poor**	**Fair**	**Good**	**Excellent**
Enter the name of the speaker, M.D.				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				

Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				

Date

Name of the Speaker(s)	Poor	Fair	Good	Excellent
Enter the name of the speaker, M.D.				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				

Date

Name of the Speaker(s)	Poor	Fair	Good	Excellent
Enter the name of the speaker, M.D.				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				

Date

Name of the Speaker(s)	Poor	Fair	Good	Excellent
Enter the name of the speaker, M.D.				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				
Enter the name of the speaker				

4. As a result of this activity, please identify a change in performance, strategy, practice, or patient care you will implement in your practice.

5. What barriers do you foresee in implementing the above change? (e.g. financial, insufficient time, organizational, language, cultural, other)

6. Funding for this conference may have come from commercial sponsors. Do you think you were adequately informed of commercial sponsorship or faculty conflict of interest? ***(Answer only after reviewing the Announcement of Disclosure attached)***

☐ **YES** ☐ **NO**

7. Do you think the presentation favored certain products or services for commercial, rather than for medical or scientific reasons?

☐ **YES** ☐ **NO**

8. Were disclosures of the presence or absence of the speakers' commercial relationships made verbally or in writing?

☐ **YES** ☐ **NO**

9. Would you recommend this activity to your colleagues?

☐ **YES** ☐ **NO**

10. Suggestions for future topics and speakers.

11. Other suggestions about the activity and areas of improvement?

12. Would you recommend this activity to your colleagues?

☐ **YES** ☐ **NO**

13. How did you hear about this activity?

☐ **Flyer** ☐ **Website** ☐ **Email** ☐ **Other Printed Matter** ☐ **Other** (describe)

14. Do you plan to attend next year's Meeting?

☐ **YES** ☐ **NO**

Faculty Disclosures:

See the Announcement of Disclosure Handout.

Record of Attendance

Please sign and return this attendance record form to validate your CME participation in this activity.

Physicians should only claim credit commensurate with the extent of their participation in the activity.

Name: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Credit Hour (s)attended: _____Telephone: _____ e-mail: _____

By signing this certificate, I attest that I have attended the above named continuing medical education program.

_____
Signature

15. Please check all that apply:

☐ MD/DO/MBBS ☐ Physician Faculty

☐ Non-Physician Faculty ☐ Residents/Fellow

☐ Students ☐ Other

Specialty:_____

Affiliation: _____

To help improve our activities, random post-survey forms will be emailed within 3 to 4 months, and your cooperation is appreciated in participating in these surveys.