**ATTENTION PARTICIPANTS**: In order to receive CME credit for participation in this program, you must have registered or signed in and you must complete and submit this evaluation form. Certificates will be emailed or faxed to you. Please print legibly.

***CME ACTIVITY EVALUATION***

**2020 Fawcett Medical Staff & Charlotte County Medical Society CME Conference**

**Certification of CME credit hours earned will be given only to those participants who complete and submit the evaluation for sessions they attend. Each physician should claim only credits that he/she actually spent in the educational activity. Credit is awarded based on the actual time spent in the activity, rounded off to the nearest quarter hour. (Ex: Two hours and 15 minutes in the CME activity = 2.25 Category 1 Credits). You MUST complete this form and return it before you can receive your credits.**

Name: (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree: MD □ DO □ Other\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Lic. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROGRAM ASSESSMENT:

1. What things did you like or enjoy about this program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Overall rating of the program: (1-5, 1= Lowest, 5 = Highest)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **SPEAKER** | Dr. Boyle | Dr. Singh | Dr. Nordgren | Dr. Fox | Dr. Salib | Dr. Koncelik | Dr. Klein |
| Stated objectives (in syllabus) were met |  |  |  |  |  |  |  |
| The speaker was qualified/effective |  |  |  |  |  |  |  |
| Visual aids/handouts (if used) were helpful |  |  |  |  |  |  |  |
| Content was accurate and current |  |  |  |  |  |  |  |
| The subject was of value for improving patient advocacy or patient care |  |  |  |  |  |  |  |
| There was sufficient time to effectively cover the subject and ask questions |  |  |  |  |  |  |  |
| The speaker disclosed his/her affiliation with commercial entities (if applicable) |  |  |  |  |  |  |  |

1. Did this educational program meet your expectations? Did not Meet □ Met □ Exceeded □
2. Was the material presented in an objective manner without commercial bias? Yes □ No □
3. Suggestions for future program topics:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE COMPLETE ONE OF THE CERTIFICATION STATEMENTS BELOW**

I certify that I attended the ***ENTIRE*** 2020 Fall Medical Staff CME Program offered on 11/07/2020

I am claiming ***7*** Prescribed Credits

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature)

***OR***

I certify that I attended a ***PORTION*** of the 2020 Fall Medical Staff CME Program offered on 11/07/2020

I am claiming \_\_\_\_\_\_\_\_\_\_\_ Prescribed Credit(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature)

***ISSUANCE OF CME CERTIFICATES:***

Charlotte County Medical Society will issue CME certificates to all participates who submit a completed CME Evaluation Form.

This Program has been approved by the American Academy of Family Physicians (AAFP) for ***7*** Prescribed CME’s

***Note: Each Physician is responsible for submitting and keeping records of his/her own CME credits***