

**Area Funded Event
Feedback Survey**

Workshop Name: _____ Workshop Date: _____

Facility: _____ Host: _____

1. Did you feel that this topic was relevant and important to your current clinical practice?

Strongly Agree <input type="checkbox"/>	Agree <input type="checkbox"/>	Undecided <input type="checkbox"/>	Disagree <input type="checkbox"/>	Strongly Disagree <input type="checkbox"/>
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2. Did you feel that your learning expectations were met?

Strongly Agree <input type="checkbox"/>	Agree <input type="checkbox"/>	Undecided <input type="checkbox"/>	Disagree <input type="checkbox"/>	Strongly Disagree <input type="checkbox"/>
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3. Did you feel that the workshop presenter was knowledgeable about this topic?

Strongly Agree <input type="checkbox"/>	Agree <input type="checkbox"/>	Undecided <input type="checkbox"/>	Disagree <input type="checkbox"/>	Strongly Disagree <input type="checkbox"/>
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Comments:

4. Did you feel the presenter provided a good learning experience?

Strongly Agree <input type="checkbox"/>	Agree <input type="checkbox"/>	Undecided <input type="checkbox"/>	Disagree <input type="checkbox"/>	Strongly Disagree <input type="checkbox"/>
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Comments:

5. Did you feel the method of presentation for the workshop (e.g. in-person presenter, videoconferencing) was comfortable and appropriate for this type of workshop?

Strongly Agree <input type="checkbox"/>	Agree <input type="checkbox"/>	Undecided <input type="checkbox"/>	Disagree <input type="checkbox"/>	Strongly Disagree <input type="checkbox"/>
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Comments:

6. How would you improve this workshop?