Education Feedback Form

A. Program	
Title of Session:	Date:
Speakers:	

B. Participant Information
First and Last Name:
What is your area of professional practice? *(e.g., physician: family practice or specialist, resident, nurse, physiotherapist, etc.)*
What is your practice location? *(e.g., name of hospital, clinic, community agency, etc.)*

C. Educational Experience	*Strongly Disagree*				*Strongly Agree*	*N/A*
1. The speaker/ presenter was effective.	1	2	3	4	5	6
2. The technology used to facilitate this session was satisfactory.	1	2	3	4	5	6
3. Your practice has been enhanced because of this session.	1	2	3	4	5	6
4. This session has reduced your professional isolation.	1	2	3	4	5	6
5. Overall, you were satisfied with this session.	1	2	3	4	5	6

D. Tell Us More	*Strongly Disagree*				*Strongly Agree*	*N/A*
1. The session met its stated objectives.	1	2	3	4	5	6
2. The session was effectively organized.	1	2	3	4	5	6
3. Discussion time was adequate.	1	2	3	4	5	6
4. The video component of the session was satisfactory.	1	2	3	4	5	6
5. The audio component of the session was satisfactory.	1	2	3	4	5	6
6. Handouts and other learning aids were satisfactory.	1	2	3	4	5	6

Comments
What suggestions, comments, topics, or speakers would you recommend to OTN? Other Comments:

Thank you for your feedback and ideas. Please complete and fax to 416-446-4139

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