Instructions
The information you provide on this form is indicative of your participation in this activity. Your responses will only be shared with presenters and planning committee members in aggregate format. Upon completion of the form, please submit the form by email to ProjectECHO@med.unr.edu or fax it to (775) 327-5112. Only those individuals who complete and return this form will receive credit.

Name: [ ]

Address: [ ]

City: [ ] State: [ ] Zip: [ ]

Telephone: [ ] License Number: [ ] Email: [ ]

1. In which setting do you work?
   - [ ] Federally Qualified Health Center (FQHC)
   - [ ] Office-based Opioid Treatment (OBOT)
   - [ ] Opioid Treatment Program (OTP)
   - [ ] Certified Community Behavioral Health Clinics (CCBHC)
   - [ ] Hospital/Emergency Room
   - [ ] Rural Health Clinic
   - [ ] Other (please describe): [ ]

2. Are you currently Data-2000 buprenorphine waivered? [ ] Yes [ ] No If no, reason:

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SIGNATURE AND VERIFICATION OF ATTENDANCE

I attest that I have participated in ________ hours of this educational activity. (M A X I M U M 1 H O U R )

This Program has been approved for AMA PRA, Pharmacy, and Nursing Credits.

 Signature __________________________ Date _____________

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As a result of my participation in this CME activity:

Please rate your overall satisfaction with this clinic session.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

- Televideo connection.
- Information provided.
- Time for questions/answers.
- Relevance to your practice.

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3. If you plan to make changes in your practice, please identify any barriers that you perceive in implementing these changes (select all that apply).

- Lack of time to assess patients
- Lack of time to counsel patients
- Insurance/Reimbursement issues
- Patient compliance issues
- Other (please describe): [ ]

- Lack of consensus on professional guidelines
- Lack of knowledge to do so
- Lack of management/clinic support
- None – I do not plan to make any changes
- None – I am able and plan to make changes

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4. Was the material presented in a manner that was free from commercial bias? [ ] Yes [ ] No If no, please explain:

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5. Please list topics of future interest and additional comment regarding teleECHO clinics: