EVALUATION AND CME/CE CREDIT CLAIM FORM
Pain Management Clinic
February 7th, 2018

University of Nevada, Reno School of Medicine
Project ECHO

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:

Last *First* *MI* *Degree*

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:*

SIGNATURE AND VERIFICATION OF ATTENDANCE

I attest that I have participated in _____ hours of this educational activity. *(MAXIMUM 1 HOUR)*
This Program has been approved for AMA PRA, Pharmacy, and Nursing Credits.

Signature **Date**

As a result of my participation in this CME activity:	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Please rate your overall satisfaction with this clinic session.	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
My knowledge increased.	5	4	3	2	1	Televideo connection.	5	4	3	2	1
My ability to provide appropriate care to my patients improved.	5	4	3	2	1	Information provided.	5	4	3	2	1
I will make changes in my practice.	5	4	3	2	1	Time for questions/answers.	5	4	3	2	1
I feel a decreased sense of professional isolation.	5	4	3	2	1	Relevance to your practice.	5	4	3	2	1

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

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

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