EVALUATION AND CME/CE CREDIT CLAIM FORM
Pain Management Clinic
March 7th, 2017

University of Nevada, Reno School of Medicine
PROJECTECHO
CONNECTING NEVADA'S COMMUNITIES TO SPECIALTY CARE

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 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:

SIGNATURE AND VERIFICATION OF ATTENDANCE

I attest that I have participated in _____ hours of this educational activity. *(MAXIMUM 1 HOUR)*

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

1. **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**
   - ☐ **Other (please describe):**
   - ☐ **Patient compliance issues**
   - ☐ **Lack of consensus on professional guidelines**
   - ☐ **None – I do not plan to make any changes**

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

3. **Please list topics of future interest and additional comments regarding teleECHO clinics:**