Evaluation and CME/CE Credit Claim Form
Pain Management Clinic
March 7th, 2017

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:

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

Please rate your overall satisfaction with this clinic session.

<table>
<thead>
<tr>
<th>Very Satisfied</th>
<th>Satisfied</th>
<th>Neutral</th>
<th>Dissatisfied</th>
<th>Very Dissatisfied</th>
</tr>
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</tr>
</tbody>
</table>

1. My knowledge increased. ____________

2. My ability to provide appropriate care to my patients improved. ____________

3. I will make changes in my practice. ____________

Please rate your overall satisfaction with this clinic session.

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Time for questions/answers. ____________

Televideo connection. ____________

Information provided. ____________

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:

____________________________________

____________________________________

____________________________________

____________________________________

OCME 01-13