

**EVALUATION AND CME/CE CREDIT CLAIM FORM**  
**Pain Management Clinic**  
**April 18<sup>th</sup>, 2018**



**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?

- |   |  |
|---|--|
| <input type="checkbox"/> Federally Qualified Health Center (FQHC) | <input type="checkbox"/> Certified Community Behavioral Health Clinics (CCBHC)                     |
| <input type="checkbox"/> Office-based Opioid Treatment (OBOT)     | <input type="checkbox"/> Hospital/Emergency Room <input type="checkbox"/> Other (please describe): |
| <input type="checkbox"/> Opioid Treatment Program (OTP)           | <input type="checkbox"/> Rural Health Clinic   |

2. Are you currently Data-2000 buprenorphine waived?       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).

- |   |   |
|---|---|
| <input type="checkbox"/> Lack of time to assess patients  | <input type="checkbox"/> Lack of consensus on professional guidelines |
| <input type="checkbox"/> Lack of time to counsel patients | <input type="checkbox"/> Lack of knowledge to do so                   |
| <input type="checkbox"/> Insurance/Reimbursement issues   | <input type="checkbox"/> Lack of management/clinic support            |
| <input type="checkbox"/> Patient compliance issues        | <input type="checkbox"/> None – I do not plan to make any changes     |
| <input type="checkbox"/> Other (please describe):         | <input type="checkbox"/> 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: