SPINAL SCREENING WORKSHOP EVALUATION

DATE: _____ LOCATION: _____
TRAINER: _____

Your Professional Affiliation: MD____DO____DC____RN____LVN____Aide____Volunteer____

Other (specify): _____

For each item below, please circle the number that reflects your evaluation: POOR, FAIR, AVERAGE, GOOD, or EXCELLENT. If an item is not applicable, write "NA" next to that entry.

TOPIC AND TRAINER(S):	**POOR**	**FAIR**	**AVERAGE**	**GOOD**	**EXCELLENT**
1. Introductory presentations or remarks	**1**	**2**	**3**	**4**	**5**
2. Overall quality of instruction	**1**	**2**	**3**	**4**	**5**
3. Overall quality of curriculum content	**1**	**2**	**3**	**4**	**5**
4. Relevance of concepts and their applicability to do job responsibilities	**1**	**2**	**3**	**4**	**5**
5. Trainer(s') ability to relate theory to practice	**1**	**2**	**3**	**4**	**5**
6. Opportunities for participant interaction	**1**	**2**	**3**	**4**	**5**
7. Appropriateness of workshop format (i.e. length of sessions, etc.)	**1**	**2**	**3**	**4**	**5**
8. Stated objectives met	**1**	**2**	**3**	**4**	**5**
ENVIRONMENT AND EQUIPMENT					
1. Materials, handouts, etc.	**1**	**2**	**3**	**4**	**5**
2. Visual aids, illustrations	**1**	**2**	**3**	**4**	**5**
3. Workshop facilities (Room, equipment, breaks, etc.)	**1**	**2**	**3**	**4**	**5**
4. Provisions for comfort of participants	**1**	**2**	**3**	**4**	**5**
5. Practicum procedures	**1**	**2**	**3**	**4**	**5**
6. Written tests	**1**	**2**	**3**	**4**	**5**

COMMENTS: _____

_____

_____