

ACTIVITY EVALUATION FORM FOR CALIFORNIA SPECIALIZATION EDUCATION

Please complete and return to Provider (Please Print)

Provider Name: _____ Provider Number: _____
 Provider Telephone Number: _____
 Provider Address: _____
 Title of Activity: _____
 Date(s) of Activity: _____
 Time of Activity: _____
 Location of Activity: (City/State) _____

- Directions: Please mark the appropriate box to indicate your evaluation of this course.** **YES** **NO**
1. Did this program meet your educational objectives? [] []
 Comments: _____
 2. Did the environment have a positive influence on your learning experience? [] []
 Comments: _____
 3. Were you provided with substantive written materials? [] []
 Comments: _____
 4. Did the course update or keep you informed of your legal responsibilities? [] []
 Comments: _____
 5. Did the activity contain significant current professional content? [] []
 Comments: _____

Please rate the faculty on a scale of 1 to 5 (1 being the lowest; 5 being the highest).

	Overall Teaching Effectiveness	Effectiveness of Teaching Methods	Significant Current Knowledge of Subject
Instructor's Name: _____	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Subject/Topic: _____			
Comments: _____			
Instructor's Name: _____	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Subject/Topic: _____			
Comments: _____			
Instructor's Name: _____	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Subject/Topic: _____			
Comments: _____			
Name of Participant: _____			
<i>(Optional)</i>	<i>First</i>		<i>Last</i>