C**ontinuing Education Evaluation**

***(Insert Designated Provider agency Name Here)***

 *(Insert Name of CE Offering Here)*

**Please circle the discipline(s) for which you would like to receive continuing education credit:**

DMH Mental Health Therapist DMH Addictions Therapist Licensed DMH Administrator DMH IDD Therapist

DMH Community Support Specialist DMH Certified Peer Support Specialist

Attendance Certificate

**Session:** Session Name

**Presenter:** Presenter Name

**Date:** Date

**Time:** Time

**Overall Goal of Session:** List the Goal of the session

**Objectives:** (By completion of this activity, the participant will be able to)

1. Objective 1
2. Objective 2
3. Objective 3

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please circle one response per question below.** | **Strongly Agree** | **Agree** | **Disagree** | **Strongly Disagree** | **Not Applicable** |
| I was able to achieve the educational objectives for this activity: **Objective 1** | **5** | **4** | **3** | **2** | **1** |
| I was able to achieve the educational objectives for this activity: **Objective 2** | **5** | **4** | **3** | **2** | **1** |
| I was able to achieve the educational objectives for this activity: **Objective 3** | **5** | **4** | **3** | **2** | **1** |
| The educational objectives were related to the overall purpose. | **5** | **4** | **3** | **2** | **1** |
| The presenter(s) demonstrated expertise in the subject matter. | **5** | **4** | **3** | **2** | **1** |
| The instructional process (teaching strategy) was effective. | **5** | **4** | **3** | **2** | **1** |
| The physical facilities were appropriate. | **5** | **4** | **3** | **2** | **1** |

**Additional Presentation Questions:**

1. Did you detect commercial bias in this presentation? **No** **Yes**
	1. If yes, please explain what made you feel bias. By whom?
2. Was there discussion of an unlabeled or the investigational use of a product, device, or drug that has not been approved by the FDA for the use being presented? **No** **Yes**
	1. If yes, please explain.
3. How will you use the information to assist you in your practice?
4. How much did you learn as a result of this continuing education opportunity? (**1 being very little- 5 being a great deal**)

**1 2 3 4 5**

1. Please list any additional comments and/or program improvements below.

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1. I would like the Mississippi Department of Mental Health, Division of Professional Development to provide conferences or workshops on the following topics**:**

**General Questions:**

1. Do you prefer:Half-Day Workshops Full-Day Workshops Multi-Day Workshops
2. Do you prefer workshops in: Hotels Hospital No preference
3. How much time do you need to respond to a program announcement?

Less than 1 month 4-6 weeks More than 6 weeks

1. How did you learn about this program?

Brochure Supervisor College Other

1. How far did you travel to attend this program?

0-25 miles 25-50 miles 50-100 miles over 100 miles

**If you have any comments or concerns regarding this training session, please contact *(insert name of Designated Provider Agency)* within 90 days of activity completion.**

**Thank you for your participation in this evaluation!**

**Signature of Participant Email Address (required)**

**Printed Name of Participant Mailing Address (optional)**