University of Massachusetts Medical School
ACTIVITY EVALUATION

Activity Title: _____

Activity Date: _____

Current Status: ___MD ___RN ___RPh ___PhD ___Resident ___ Medical Student ___Other

1. **How would you rate this educational activity overall?**
   (5 = excellent, 1 = poor, please circle one) 5 4 3 2 1

2. **In your opinion, did you perceive any commercial bias in any of the presentations?**
   ☐ Yes If yes, please explain:_____
   ☐ No

3. **Do you plan on making any changes in your practice as a result of this activity?**
   ☐ Yes If yes, please explain: _____
   ☐ No

4. **What barriers, if any, do you anticipate encountering as you make changes in your practice?**

_____

5. **Do you feel each of the following objectives was met?**

• Insert Objective 1	☐Yes ☐No ☐Partially ☐N/A
• Insert Objective 2	☐Yes ☐No ☐Partially ☐N/A
• Insert Objective 3 (Please add additional spaces for additional objectives)	☐Yes ☐No ☐Partially ☐N/A

6. **Do you feel that the information presented was based on the best evidence available?**
   ☐ Yes If no, please explain:
   ☐ No

7. **Which of the following competency areas do you feel have been improved as a result of this activity? Select all that apply**
   ☐ **Patient Care** ☐ **Professionalism** ☐ Practice Based Learning ☐ Medical Knowledge ☐ Communication Skills ☐ System Base Practice

8. **Please suggest topics for future activities.**
   _____

9. **Please rate the quality of the following presentations**. (5 = Excellent, 1 = Poor)
   Insert faculty name **5 4 3 2 1**
   Insert faculty name **5 4 3 2 1**

General Comments:

Comment [KB1]: Activity title and date should be completed by the RSS Coordinator

Comment [KB2]: These objectives must be customized for each presentation of the Regularly Scheduled Series

Comment [KB3]: This should be customized for each session