



California Hospice & Palliative Care Association & Association
“VA & Hospice: Working Together”
Evaluation Form ♦ CHAPCA Regional Meeting Workshop

Your evaluation of this program and suggestions for the future are important to AHCNC and CHAPCA. Please take the time to share your thoughts with us by completing this form and turning it in at the conclusion of the program. Your Continuing Education Certificate will be e-mailed to you following the seminar. We would appreciate your input even if you are not requesting continuing education credits for this course. Certificates of Attendance are also available upon request.

	Low			High		
1. Overall rating of the program	1	2	3	4	5	6
2. Did this program meet stated objectives?	1	2	3	4	5	6
3. Relevancy of information	1	2	3	4	5	6

**THIS FORM MUST BE
 COMPLETELY FILLED OUT
 TO RECEIVE CONTINUING
 EDUCATION CREDIT**

4. Speaker Effectiveness: **Ann Hablitzel, RN, BSN, MBA**

	Low			High		
Knowledge of topic	1	2	3	4	5	6
Organization & content	1	2	3	4	5	6
Quality of handouts	1	2	3	4	5	6
Clarity	1	2	3	4	5	6
Responsiveness to participants	1	2	3	4	5	6
Allocation of program time to subject area	1	2	3	4	5	6
Applicability of program content to on-the-job performance	1	2	3	4	5	6
Overall Quality	1	2	3	4	5	6

Please Indicate the Workshop You Attended:

Tuesday, October 12 - Modesto

Tuesday, October 19 - San Diego

Wednesday, October 20 - Orange County

Thursday, October 21 - San Bernardino

Tuesday, October 26 - Redding

November - Sacramento Area

Friday, December 10 - San Jose Area

5. Identify two specific things you learned today: _____

6. If any part of the program was of little or no value to you, please indicate which part and why: _____

7. Future topics you'd like to see addressed by CHAPCA: _____

In order to receive continuing education credits for this course, you must complete the following information and fax or mail the completed form to California Hospice & Palliative Care Association, 3841 North Freeway Blvd., #225, Sacramento, CA 95834 or FAX: (916) 925-3780.

Print Name as it Should Appear on Certificate: _____

Organization: _____

E-mail Address Where Certificate Should be Sent: _____

LICENSE INFORMATION

RN/LVN/BRN Attendance

HHA/CNA

MSW/LCSW/MFT

License # _____