PROGRAM EVALUATION

Participant’s Name:       Date:

License Type (RN etc) & State:

Participants Email:

Program Title: What’s Driving Your Referral Sources Strategies to Expand Care in the Home?

Ability to meet course objectives were met: Yes [ ]  No [ ]

The subject matter was specific to outline: Yes [ ]  No [ ]

The information presented was current to meet your needs: Yes [ ]  No [ ]

The information was presented in an effective manner: Yes [ ]  No [ ]

The information presented was educationally appropriate: Yes [ ]  No [ ]

The program has met your professional needs: Yes [ ]  No [ ]

 The program was appropriate in length: Too Long Adequate Too Short

 [ ]  [ ]  [ ]

Please list any topics that you would like to have presented in the future for continuing education:

Please list any additional comments about the program, instructor(s), or the facility

**\*\**Required to receive credit*\*\***

**1. Keyword(s) provided during the webinar**:

**I certify that I participated in and attended the entire session of the following web cast course on this date. Submitting a false or fraudulent certificate of completion to the Board may subject any application for a license to denial, and any issued license to suspension or revocation.**

**2. Signature**