DISTRICT NAME AND ADDRESS

COURSE EVALUATION

Your feedback is important to us!

Please complete and return this form so that we can continue to respond to your educational needs.

Course Title: Date:

Instructor(s):

Please select which category best describes your professional status. (Please select only one.)

☐ Dentist ☐ Hygienist ☐ Assistant ☐ Office Personnel ☐ Guest/Spouse ☐ Student ☐ Other

Please rate this course on the various aspects listed using the scale below.

	Excellent	Good	Fair	Poor	No Opinion	Not Applicable
Were the teaching methods effective?	5	4	3	2	1	0
How well did the course meet your expectations?	5	4	3	2	1	0
How well did the course content relate to the stated educational objectives?	5	4	3	2	1	0
How well will you be able to implement the information gained from this course?	5	4	3	2	1	0
Were your personal objectives for participation satisfied?	5	4	3	2	1	0
Was the length of this course appropriate?	5	4	3	2	1	0
Was the course content useful, comprehensive, and adequately in-depth?	5	4	3	2	1	0
Were the handouts and AV materials appropriate and useful?	5	4	3	2	1	0
What overall rating would you give the course instructor?	5	4	3	2	1	0
What overall rating would you give the administration of the course?	5	4	3	2	1	0
What overall rating would you give for this course?	5	4	3	2	1	0

Would you attend a course on this topic again? ☐ Yes ☐ No

What changes will you make in your practice as a result of this session?_____

_____

Was there corporate influence in this program? ☐ Yes ☐ No If yes, please explain: _____

_____

Are there any additional topics you would like to see presented in the future?_____

_____

Additional Comments:_____

_____

May we quote you? Name: _____ **Phone:** _____ **E-mail:**_____