

**Howard University College of Medicine  
Office of Continuing Medical Education**

**CME FACULTY/SPEAKER'S EVALUATION FORM**

Please complete the information requested on this form and return to the Office of Continuing Medical Education **or the presenting department/organization** within the next five days.

Program Title \_\_\_\_\_ Date \_\_\_\_\_

- |  | Yes   | No    |
|--|-------|-------|
| 1. Adequate notice from the office/department requesting your participation?                   | _____ | _____ |
| 2. Adequate support from the office/department during preparation for lecture, workshop, etc.? | _____ | _____ |
| 3. Adequate choice in topic?   | _____ | _____ |
| 4. Adequate audiovisual support?   | _____ | _____ |
| 5. Adequate meeting room accommodations?   | _____ | _____ |
| 6. Desire to participate again?  | _____ | _____ |
| a. Preferred topic _____   |       |       |
| b. I prefer    ( ) Workshop    ( ) Lecture    ( ) Panel    ( ) Small-group Discussion          |       |       |

7. Suggestions on how the **activity** can be improved:

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8. Other suggestions for topics (by others):

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Name \_\_\_\_\_

Phone: 202-806-5621/22

Fax: