

Satisfaction with Session Presentation: Family Centered Care

Resident's Name: _____

Date of Visit: _____

Please respond to the following statements by circling your response on a scale from 1 to 5.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

The Facilitators:

- | | | | | | |
|---------------------------------------|---|---|---|---|---|
| 1. Were prepared for the session. | 1 | 2 | 3 | 4 | 5 |
| 2. Were organized. | 1 | 2 | 3 | 4 | 5 |
| 3. Stated clear objectives. | 1 | 2 | 3 | 4 | 5 |
| 4. Were articulate/spoke clearly. | 1 | 2 | 3 | 4 | 5 |
| 5. Allowed enough time for questions. | 1 | 2 | 3 | 4 | 5 |
| 6. Sufficiently answered questions. | 1 | 2 | 3 | 4 | 5 |
| 7. Valued my input. | 1 | 2 | 3 | 4 | 5 |

The Content:

- | | | | | | |
|--|---|---|---|---|---|
| 8. Objectives of the session were met. | 1 | 2 | 3 | 4 | 5 |
| 9. The session provided me with a clear understanding of Family Centered Care. | 1 | 2 | 3 | 4 | 5 |
| 10. Overall rating of the session | 1 | 2 | 3 | 4 | 5 |
11. What, if anything, would you like to see added to or omitted from the Family Centered Care didactic session?

Please return this form to:
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