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Videoconferenced Regularly Scheduled Series REGISTRATION FORM

Course Objective(s):

Date viewed event: _____

Accessed using Computer Telemedicine Equipment

Provider UCD/CME UCTV Other _____

Organization: UCSF UCDHS KAISER OTHER _____

If you are a UC Davis Affiliate: (CHECK ONE)

FACULTY

CLINICAL FACULTY

PCN FACULTY

VOLUNTEER FACULTY

SOM ALUMNI

OTHER _____

OCCUPATION:

NP RN MSW LCSW

TECH CRNA OPTOMETRIST

PA RD Other _____

MD or DO need specialty
Specialty : _____

Medical Student Resident Fellow

NAME: _____ Last 4 digits of your SSN#: xxx-xx-_____ (For transcript purposes)

MAILING ADDRESS: _____
(address you would like us to mail your complimentary annual transcript)

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **FAX:** _____

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Mail or fax REGISTRATION FORM and EVALUATION to:
Gwenn Welsch - Distance Education Phone (916) 734-5773 Fax (916) 734-0776
Continuing Medical Education
3560 Business Drive, Suite 130, Sacramento, CA 95820

CONFIDENTIALITY STATEMENT

I understand and agree that I shall respect and maintain the confidentiality of all discussions, deliberations, records, and any other information generated in connection with these activities by the medical staff, departments, divisions, or their committees. I shall make no voluntary disclosures of such discussion, deliberations, records, and information except to persons authorized to receive it in the conduct of medical staff affairs.

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University of California, Davis, Health System
OFFICE OF CONTINUING MEDICAL EDUCATION - EVALUATION FORM

Name: _____ SS# XXX-XX _____

Remote Site - Clinic/Hospital Name: _____

MD DO Specialty _____ RN NP PA Other _____

Learner Objectives

At the completion of this program the participant should be able to :

Speaker:	RATING* Excellent <input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Poor
Comments regarding content and presentation: _____	
This RSS fits the scope of my medical practice.	Agree <input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Disagree
I have increased my competence as a result of attending this RSS	Agree <input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Disagree
I will apply knowledge and strategy from this RSS in my clinical practice	Agree <input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Disagree
What clinical problems have you been able to solve as a result of attending this RSS? _____	
This presentation was free from commercial bias. If a conflict of interest was noted, please specify.	Agree <input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Disagree
Issues in cultural/linguistic competency were adequately addressed in this activity (e.g. difference in prevalence, diagnosis, treatment in diverse population; linguistic skills; pertinent cultural data).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Resources on cultural and linguistic competency are available on the OCME web site at http://cme.ucdavis.edu under AB1195. How can we further meet your educational needs in this area? _____	
What are your needs for future educational interventions/activities? _____	
Additional comments: _____	