Cicatelli Associates Inc.
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New York, NY 10018
Ph: 212.594.7741
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PLEASE DO NOT USE A FAX COVER PAGE

ATTN: Alma Krcic

Date: ____________________ No. of Pages: ______

ATTENDANCE VERIFICATION

Preconception Counseling in Family Planning
January 19, 2011
1.5 Nursing Contact Hour(s)

Instructions: To receive a CNE certificate, complete this form, the demographic and program evaluation forms. Submit them together by fax to Alma Krcic at 212-629-3321 by Friday, February 4, 2011. These forms must be received together in order to receive a certificate. Respondent's information will be held confidential.

TITLE/DEGREE: CNM ☐ PHN ☐ NP ☐ LPN ☐ RN ☐

OTHER ____

THE ADDRESS PROVIDED BELOW IS MY ☐ HOME ☐ WORK ADDRESS:

First Name ____________________ Last Name ____________________

Agency Name (if applicable) ____________________

Address ____________________ City, State, & Zip ____________________

Email Address ____________________ Telephone Number (   ) ____________________

Physicians should only claim credit commensurate with the extent of their participation in the activity.

Scheduled Hour(s)	1:00 – 2:30 pm
Maximum Credit Hour(s)	1.5
Actual Hour(s) of Attendance	

What type of credit are you requesting? Please check ONLY one:

☐ CNE Certificate

☐ Certificate of Attendance

Program ID: 14903

progid

Cicatelli Associates Inc.

Anonymous Participant Demographic Form

To target our services better, we are asking all of our participants to complete the following information.

Gender
- ○ Female
- ○ Transgender
- ○ Male
- ○ Intersex

Age [ ][ ]

Are you of Hispanic, Latino, or Spanish origin?
- ○ Yes
- ○ No

Race (select all that apply)
- ○ American Indian/Alaskan Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian/Other Pacific Islander
- ○ White
- ○ Other: ________________

Highest level of formal education
- ○ Less than High School Diploma
- ○ High School Diploma/GED
- ○ Some College
- ○ Associate's Degree
- ○ Bachelor's Degree
- ○ Master's Degree
- ○ Doctoral Degree

Advanced degrees and certifications (select all that apply)

○ MD/DO	○ CNA	○ RD	○ MPH
○ PA	○ LPN/LVN	○ CHES	○ MSc
○ DDS	○ RN	○ CASAC	○ MA
○ OD	○ NP	○ LCSW	○ MS
○ PhD	○ CNM	○ LPC	○ Other (fill in below)
○ JD	○ CNS	○ LMHC	[ ][ ][ ][ ][ ]
○ CPA	○ ACRN	○ MSW	

Primary functional role(s) (select all that apply)

○ Accounting	○ Medical Director
○ Administrator/Supervisor	○ Nutritionist
○ Board Member	○ Outreach Worker
○ Care Provider/Clinician	○ Patient Advocate/Navigator
○ Case Mgmt. Technician	○ Peer Educator/Advocate
○ Case Manager	○ Program Director
○ Childcare Worker	○ Program Manager/Coord.
○ Clergy/Spiritual Leader	○ Psychiatrist
○ Community Follow-Up Worker	○ Psychologist
○ Counselor/Therapist	○ Social Worker
○ Data Manager	○ Student/Graduate Student
○ Epidemiologist	○ Trainer/Teacher/Faculty
○ Financial Manager	○ Volunteer
○ Health Educator	○ Not Working/Not Employed
○ Medical Assistant	○ Other

How long have you been in your primary functional role? [ ][ ] years

Area(s) of specialization (select all that apply)

○ Adolescent Health	○ Pediatrics
○ CAM	○ Prenatal Care/OB/Gyn
○ Criminal Justice	○ Primary Care
○ Early Childhood	○ Reproductive Health
○ Education	○ Research
○ HIV/AIDS	○ STIs/STDs
○ Information Systems	○ Substance Abuse
○ International Health	○ Tobacco Control
○ Mental Health	○ Violence Prevention
○ Nutrition/Obesity	○ Other
○ Oncology/Cancer	

How long have you been in your primary area of specialization? [ ][ ] years

Principal employment setting (select all that apply)

○ Adolescent Health Center	○ EMS/Police/Fire	○ Homeless Shelter	○ School/Educational Institution
○ CBO/Community Agency	○ Faith-Based Org.	○ Hospice/Palliative Care	○ State/Local Health Dept.
○ Child Welfare Services/Foster Care	○ Family Planning Agency	○ Hospital or Hospital-Based Clinic	○ STD Clinic
○ Community/Migrant Health Ctr.	○ HIV/AIDS Service Org.	○ Long-Term Care Facility	○ Substance Abuse Treatment Prg
○ Correctional Facility	○ HMO/Managed Care Org.	○ Mental Health Facility	○ Tribal/Indian Health Center
○ Domestic Violence/Rape Crisis Ctr.	○ Home Care	○ Private Practice	○ Other
○ Early Childhood Facility			

Zip-code of your principal employment setting [ ][ ][ ][ ][ ]

Location of your principal employment setting
- ○ Urban
- ○ Suburban
- ○ Rural
- ○ Indian Reservation

Thank you for completing this questionnaire!

(July 2007)

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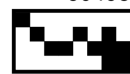

PROGRAM EVALUATION

Program Title: Preconception Counseling in Family Planning **Date:** January 19, 2011 **Program ID:** 14903

PLEASE RATE THE PRESENTATION ON A SCALE OF 1 (LOWEST) TO 5 (HIGHEST):

Circle your answers

		Poor	Fair	Good	Very Good	Excellent
1.	To what extent did the presentation meets its stated objectives:					
	a. Define preconception, inter-conception and reproductive life planning	1	2	3	4	5
	b. Recognize the rationale for integrating pre-conception and inter-conception care into family planning services	1	2	3	4	5
	c. Discuss strategies for integrating preconception counseling into the family planning visit	1	2	3	4	5
2.	To what extent did the objectives relate to the overall purpose?	1	2	3	4	5
3.	Your satisfaction with your level of participation during the presentation.	1	2	3	4	5
4.	Usefulness of the instructional materials.	1	2	3	4	5
5.	Degree to which this was a good learning experience.	1	2	3	4	5
6.	Overall satisfaction with the presentation.	1	2	3	4	5

PLEASE RESPOND TO THE FOLLOWING (print your answers)**:**

7. The most useful part of the presentation was:

____

____

8. The least useful part of the presentation was:

____

____

9. As a result of attending this presentation, I plan to:

____

____

10. The mix of theory and skill practice at this presentation was:

☐ too much theory ☐ too much practice ☐ a good mix of both

PLEASE RATE THE FACILITATOR(S) ON A SCALE OF 1(LOWEST) TO 5 (HIGHEST):

Circle your answer for each facilitator on the line indicated.

11.	I felt the facilitator(s):	Name	Disagree				Agree
a.	Knew the subject matter thoroughly.	**Iris Stendig-Raskin**	1	2	3	4	5
b.	Presented the information clearly.	**Iris Stendig-Raskin**	1	2	3	4	5
c.	Provided opportunities for participation.	**Iris Stendig-Raskin**	1	2	3	4	5
d.	Provided opportunities for questions.	**Iris Stendig-Raskin**	1	2	3	4	5
e.	Was able to hold my attention.	**Iris Stendig-Raskin**	1	2	3	4	5
f.	Extent to which the teaching methods were effective.	**Iris Stendig-Raskin**	1	2	3	4	5

a.	Knew the subject matter thoroughly.	**Amanda Brown**	1	2	3	4	5
b.	Presented the information clearly.	**Amanda Brown**	1	2	3	4	5
c.	Provided opportunities for participation.	**Amanda Brown**	1	2	3	4	5
d.	Provided opportunities for questions.	**Amanda Brown**	1	2	3	4	5
e.	Was able to hold my attention.	**Amanda Brown**	1	2	3	4	5
f.	Extent to which the teaching methods were effective.	**Amanda Brown**	1	2	3	4	5

12. What changes would you recommend for improving this presentation?

____

____

13. What additional presentations would you like to attend in the future?

____

____

14. Please rate your experience using this web-based training forum by visiting www.cicatelli.org\evals. Thank you.

15. Additional comments:

____

____

IF YOU ARE REQUESTING A CNE CERTIFICATE, PLEASE RESPOND TO THE FOLLOWING:

1. What is your medical profession?

☐ MD ☐ DO ☐ APN/NP ☐ PA

☐ RN ☐ PhD ☐ Other (please specify) ____________________________

2. Continuing Education presentations “must be free of commercial bias for or against any product.” In your opinion, was this program fair, balanced and free of commercial bias? ☐ Yes ☐ No

3. What percentage of the material presented is new to you?

☐ 0% ☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100%

4. After attending this presentation, will you make any changes to your practice? ☐ Yes ☐ No

5. If yes, explain how:

____

____

6. If no, list the barriers that affect change in your practice:

____

____