

## Attachment 1-4: ATTC Post Event Customer Satisfaction Survey—

### Training

**Personal Code:** First letter of mother's first name: \_\_\_ First letter of mother's maiden name: \_\_\_  
 First digit of social security number: \_\_\_ Last digit of social security number: \_\_\_

**ATTC staff – enter Event Code in this box.**

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
1. How satisfied are you with the overall quality of this training?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How satisfied are you with the quality of the instruction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How satisfied are you with the quality of the training materials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Overall, how satisfied are you with your training experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE INDICATE YOUR AGREEMENT WITH THESE STATEMENTS ABOUT THE TRAINING.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5. The training class was well organized.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The material presented in this class will be useful to me in dealing with substance abuse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The instructor was knowledgeable about the subject matter.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. The instructor was well prepared for the course.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. The instructor was receptive to participant comments and questions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I am currently effective when working in this topic area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. The training enhanced my skills in this topic area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. The training was relevant to my career.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I expect to use the information gained from this training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I expect this training to benefit my clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. This training was relevant to substance abuse treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I would recommend this training to a colleague.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I have adequate knowledge in this training area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. I possess the skills required in this topic area.
- Very Useful      Useful      Neutral      Useless      Not Applicable
19. How useful was the information you received from the instructor?

20. Please indicate which title best describes your job:
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Medical Director              | <input type="checkbox"/> Clinical Administrator/Manager | <input type="checkbox"/> Federal Government Official  |
| <input type="checkbox"/> Physician                     | <input type="checkbox"/> Clinical Supervisor            | <input type="checkbox"/> State Government Official    |
| <input type="checkbox"/> Nurse                         | <input type="checkbox"/> Psychologist                   | <input type="checkbox"/> County Government Official   |
| <input type="checkbox"/> Physician's Assistant         | <input type="checkbox"/> Counselor                      | <input type="checkbox"/> Researcher                   |
| <input type="checkbox"/> Pharmacist                    | <input type="checkbox"/> Social Worker                  | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Other (please describe) _____ | <input type="checkbox"/> Manager/Director               |   |

21. Please indicate which best describes your agency or affiliation:
- |   |   |
|---|---|
| <input type="checkbox"/> Federal Government | <input type="checkbox"/> Substance Abuse Treatment Program                |
| <input type="checkbox"/> State Government   | <input type="checkbox"/> University or other higher education institution |
| <input type="checkbox"/> County Government  | <input type="checkbox"/> Other (please describe) _____                    |
| <input type="checkbox"/> Local Government   |   |

22. What is your gender?  Male  Female

23. Are you Hispanic or Latino?  Yes  No

24. What is your race (Mark all that apply)?
- |  |  |
|--|--|
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Alaska Native                             |
| <input type="checkbox"/> Asian                     | <input type="checkbox"/> American Indian                           |
| <input type="checkbox"/> White                     | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |

What about the training was most useful in supporting your work responsibilities?

How can the ATTC Network improve its training?

**Thank you for completing our survey.**

*Return your survey to the Survey Administrator for your Session.*

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information to the SAMHSA Reports Clearance Officer, Room 7-1044, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0216.