Form Approved
OMB NO. 0930-0216
Exp. Date XX/XX/XXXX
See burden statement on the reverse side

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?	☐	☐	☐	☐	☐
2. How satisfied are you with the quality of the instruction?	☐	☐	☐	☐	☐
3. How satisfied are you with the quality of the training materials?	☐	☐	☐	☐	☐
4. Overall, how satisfied are you with your training experience?	☐	☐	☐	☐	☐

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

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:

- ☐ Medical Director
- ☐ Physician
- ☐ Nurse
- ☐ Physician's Assistant
- ☐ Pharmacist
- ☐ Other (please describe) _____
- ☐ Clinical Administrator/Manager
- ☐ Clinical Supervisor
- ☐ Psychologist
- ☐ Counselor
- ☐ Social Worker
- ☐ Manager/Director
- ☐ Federal Government Official
- ☐ State Government Official
- ☐ County Government Official
- ☐ Researcher
- ☐ Other (please specify)_____

21. Please indicate which best describes your agency or affiliation:

- ☐ Federal Government
- ☐ State Government
- ☐ County Government
- ☐ Local Government
- ☐ Substance Abuse Treatment Program
- ☐ University or other higher education institution
- ☐ Other (please describe) _____

22. What is your gender? ☐ Male ☐ Female

23. Are you Hispanic or Latino? ☐ Yes ☐ No

24. What is your race (Mark all that apply)?

- ☐ Black or African American
- ☐ Asian
- ☐ White
- ☐ Alaska Native
- ☐ American Indian
- ☐ 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.