Form Approved

OMB Form No. 0917-0036-15

Expiration Date: 5/31/2015

Indian Health Service (IHS)

Community Health Representatives (CHR)

Basic Training and Refresher Training Evaluation

Please provide feedback below so we can improve the quality of the CHR trainings. Where a scale is indicated (1 to 5) to rate, please use 5 as the highest, best or most, and 1 is the lowest, least, or worst . Thank you.

1. **Please rate the facilities (room size, seating, audio-visual, etc.) for the training sessions.**

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| 1 | 2 | 3 | 4 | 5 |

1. **Looking back, how would you rate your knowledge and skills before the training?**

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| 1 | 2 | 3 | 4 | 5 |

1. **Now that you have attended the training, how do you rate your knowledge and skills?**

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| 1 | 2 | 3 | 4 | 5 |

1. **Given your increased knowledge, do you feel capable and confident to act on this knowledge?**

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| 1 | 2 | 3 | 4 | 5 |

1. **How likely is it that you will change any personal behaviors/lifestyles as a result of this training?**

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| 1 | 2 | 3 | 4 | 5 |

1. **List two things (such as a new project, reporting services, use of data, improvement techniques, etc.) that you will use in your work as a result of this training.**
2. **What did you like best and least about the training?**
3. **Please evaluate the speakers:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Speaker **(as listed in the agenda)** | **Expertise of Speaker** |  | **Appropriate teaching****strategies** |
| **1** | **2** | **3** | **4** | **5** | **1** | **2** | **3** | **4** | **5** |
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Other comments:

OPTIONAL: Please provide your name and email/phone contact information if you’d like a response to your comments above from the IHS HQ CHR Program.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.