Form Approved
OMB NO. 0930-0216
Exp. Date 09/30/2016
See burden statement on the reverse side

Addiction Technology Transfer Center (ATTC) Network

Post-Event Form for Training

Participants – Please Write Your Unique Personal Code Here as Follows:			
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:**	
Office Use Only - ATTC Event Code:			

	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.	☐	☐	☐	☐	☐

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	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
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. Your gender: ☐ Female ☐ Male ☐ Transgender

21. Are you Hispanic or Latino/a? ☐ Yes ☐ No

22. What is your race? (*select one or more*):

☐ American Indian
☐ Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White
☐ Other (*please specify*) _____

23. What is the highest degree you have received (*select one*)?

☐ Some high school, but no diploma or equivalent
☐ High school diploma or equivalent
☐ Some college but no degree
☐ Associate's degree
☐ Bachelor's degree
☐ Master's degree
☐ Doctoral degree or equivalent
☐ Other (*please specify*): _____

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24. What is your **primary** profession (*select one*)?

☐ Counselor
☐ Addictions professional
☐ Social worker
☐ Recovery specialist
☐ Mental health professional
☐ Criminal justice/law enforcement professional
☐ Disease intervention specialist/investigator
☐ Community health worker
☐ Health educator
☐ Educator (post-secondary or continuing)
☐ Public or Business Administrator
☐ Researcher
☐ Physician
☐ Physician assistant
☐ Registered nurse
☐ Licensed practical nurse
☐ Advanced practice nurse
☐ Pharmacist
☐ Dentist
☐ Other dental professional
☐ Other (*please specify*)_____

25**.** If you are a student, what is your **primary** field of study (*select one*)?

☐ Not a student
☐ Psychology
☐ Medicine
☐ Pharmacology
☐ Basic, translational or applied science
☐ Addiction
☐ Public health
☐ Other (please specify)
☐ Counseling
☐ Social Work
☐ Nursing
☐ Dentistry
☐ Criminal justice/law enforcement
☐ Education
☐ Public or business administration

26. In which discipline(s) are you currently licensed or certified (*select one or more*)?

☐ Not licensed or certified
☐ Counseling
☐ Social Work
☐ Nursing
☐ Dentistry
☐ Addictions prevention, treatment or recovery
☐ Psychology
☐ Medicine
☐ Pharmacology
☐ Other (please specify)_____

27**.** Which best describes your role at your current workplace (*select one*)?

☐ Clinician / care provider/direct service provider
☐ Clinical Supervisor
☐ Recovery Specialist
☐ Manager / coordinator/administrator
☐ Client / patient educator
☐ Case manager
☐ Prevention case manager
☐ Counselor
☐ Mental health therapist
☐ Parole/Probation/Re-Entry Support
☐ Outreach staff
☐ Disease intervention/investigation
☐ Resident / fellow
☐ Teacher / faculty
☐ Trainer / TA Provider
☐ Group Facilitator
☐ Not currently employed
☐ Other (*please specify)*_____

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26. Which best describes your **principal** employment setting *(select one)*?

- ☐ Community or Faith-based service organization (CBO/FBO)
- ☐ Government (federal, state or municipal)
- ☐ State/local health department
- ☐ School/university (academic department)
- ☐ Hospital/Hospital-affiliated clinic
- ☐ HMO/managed care organization
- ☐ Solo/group private practice
- ☐ Addictions treatment program (inpatient)
- ☐ Addictions treatment program (outpatient)
- ☐ Addictions treatment program (residential)
- ☐ Recovery support program
- ☐ School/university-based health clinic
- ☐ Correctional facility
- ☐ Probation/parole office
- ☐ Local law enforcement department
- ☐ Military/VA
- ☐ Tribal/Indian Health Service
- ☐ Community health center
- ☐ Not currently employed
- ☐ Other: *(please specify)* _____

27. What is the zipcode of your principal employment setting? ☐☐☐☐☐

28. What about the training was most useful in supporting your work responsibilities?
29. How can the ATTC Network improve its training?

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First Letter of Mother's Maiden Name:	
First Digit of Social Security Number:	
Last Digit of Social Security Number:	

Thank you for completing our survey.

Return your survey to the Survey Administrator for your Session.