REQUIRED OMB INFORMATION:	

Indian Health Service (IHS) Clinical Rounds Qualitative Feedback

Form Approved
OMB Form No. 0917-0036
Expiration Date:

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2. Personal Information

For a Certificate of Continuing Education, we need the following information about you. This information is required by the accrediting bodies and will only be used in reporting information to them. Your personal information will not be shared with others or released to anyone.

Full Name Professional Credential(s) Email address Phone number Street Address City State ZIP Code Facility Name Area 2. Select the term(s) that best describes your role: Physician Physician Physician Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian Other (please describe)	
Professional Credential(s) Email address Phone number Street Address City State ZIP Code Facility Name Area 2. Select the term(s) that best describes your role: Physician Dentist Pharmacist Nurse Practitioner Physician Assistant Registered Nurse Deublic Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	1. Complete the following
Email address Phone number Street Address City State ZIP Code Facility Name Area 2. Select the term(s) that best describes your role: Physician Dentist Pharmacist Nurse Practitioner Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	Full Name
Phone number Street Address City State ZIP Code Facility Name Area 2. Select the term(s) that best describes your role: Physician Dentist Pharmacist Nurse Practitioner Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	Professional Credential(s)
Street Address City State ZIP Code Facility Name Area 2. Select the term(s) that best describes your role: Physician Dentist Pharmacist Nurse Practitioner Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	Email address
State ZIP Code Facility Name Area 2. Select the term(s) that best describes your role: Physician Dentist Pharmacist Nurse Practitioner Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	Phone number
State ZIP Code Facility Name Area 2. Select the term(s) that best describes your role: Physician Dentist Pharmacist Nurse Practitioner Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	Street Address
ZIP Code Facility Name Area 2. Select the term(s) that best describes your role: Physician Dentist Pharmacist Nurse Practitioner Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	City
Area 2. Select the term(s) that best describes your role: Physician	State
2. Select the term(s) that best describes your role: Physician Dentist Pharmacist Nurse Practitioner Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	
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□ Physician □ Dentist □ Pharmacist □ Nurse Practitioner □ Physician Assistant □ Registered Nurse □ Public Health Nurse □ Case Manager □ Licensed Practical Nurse □ Nursing Assistant □ Site Manager/IT Representative □ Clinical Applications Coordinator □ Medical Records □ GPRA Coordinator □ Registered Dietitian	Area
Dentist Pharmacist Nurse Practitioner Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	2. Select the term(s) that best describes your role:
□ Pharmacist □ Nurse Practitioner □ Physician Assistant □ Registered Nurse □ Public Health Nurse □ Case Manager □ Licensed Practical Nurse □ Nursing Assistant □ Site Manager/IT Representative □ Clinical Applications Coordinator □ Medical Records □ GPRA Coordinator □ Registered Dietitian	☐ Physician
Nurse Practitioner Physician Assistant Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	☐ Dentist
□ Physician Assistant □ Registered Nurse □ Public Health Nurse □ Case Manager □ Licensed Practical Nurse □ Nursing Assistant □ Site Manager/IT Representative □ Clinical Applications Coordinator □ Medical Records □ GPRA Coordinator □ Registered Dietitian	Pharmacist
Registered Nurse Public Health Nurse Case Manager Licensed Practical Nurse Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian	Nurse Practitioner
 □ Public Health Nurse □ Case Manager □ Licensed Practical Nurse □ Nursing Assistant □ Site Manager/IT Representative □ Clinical Applications Coordinator □ Medical Records □ GPRA Coordinator □ Registered Dietitian 	Physician Assistant
□ Case Manager □ Licensed Practical Nurse □ Nursing Assistant □ Site Manager/IT Representative □ Clinical Applications Coordinator □ Medical Records □ GPRA Coordinator □ Registered Dietitian	Registered Nurse
 □ Licensed Practical Nurse □ Nursing Assistant □ Site Manager/IT Representative □ Clinical Applications Coordinator □ Medical Records □ GPRA Coordinator □ Registered Dietitian 	☐ Public Health Nurse
 Nursing Assistant Site Manager/IT Representative Clinical Applications Coordinator Medical Records GPRA Coordinator Registered Dietitian 	☐ Case Manager
 □ Site Manager/IT Representative □ Clinical Applications Coordinator □ Medical Records □ GPRA Coordinator □ Registered Dietitian 	☐ Licensed Practical Nurse
 □ Clinical Applications Coordinator □ Medical Records □ GPRA Coordinator □ Registered Dietitian 	☐ Nursing Assistant
 Medical Records □ GPRA Coordinator □ Registered Dietitian 	☐ Site Manager/IT Representative
☐ GPRA Coordinator ☐ Registered Dietitian	☐ Clinical Applications Coordinator
Registered Dietitian	☐ Medical Records
	GPRA Coordinator
Other (please describe)	Registered Dietitian
	Other (please describe)

3. Evaluation

We would appreciate your feedback on this session. Your input will be used to help us improve our materials and presentation approach as we continue to offer educational sessions to all throughout all IHS, Tribal and Urban Facilities.

3. How well did this training session cover the following objectives?

	Poor	Fair	Good	Very Good	Excellent
Learning Objectives:	0	O	0	0	0
Participants will learn how to (TBD).	O	O	O	O	O
Participants will recognize (TBD).	0	O	O	0	O
Participants will learn (TBD).	O	O	O	O	O
Other (please specify)					

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Please describe thating.	ie quality o	of the presen	tation mate	erials and m	ethods used	in this
g.	Poor	Fair	G	ood	Very Good	Excellent
owerpoint Handout	0	0	(0	0	0
ace of Presentation	0	0		0	0	0
ength of Presentation	0	O	(0	0	0
Please describe th	ne quality o	of the service	s used in tl	his training.		
	Poor	Fair	Good	Very Good	Excellent	N/A
ne Virtual service was easy use	0	О	O	O	О	0
ne presentation computer nctioned properly	0	О	O	O	O	0
ne teleconference line nctioned properly	0	О	O	O	О	0
the training in a group tting, how would you rate e setting?						

5. Presenter(s) Evaluation

Please rate the presenter(s).

6. Presenter Information (TBD)

Poor	Fair	Good	Very Good	Excellent
O	0	O	O	0
O	0	O	O	0
0	0	0	0	0
0	O	0	0	0
0	0	O	O	0
0	O	O	O	0
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6. General Questions
7. Do you intend to change your practice as a result of this activity?
C Yes (If yes, please provide an example of that change in the comment section below)
C No
C Maybe
Comment
8. Did you perceive any commercial bias toward any particular product or company in any part of the presentation?
C Yes
O No
Comment
9. What part of the presentation did you find most useful?
10. What additional information would you have liked to learn?
11. What additional topics would you recommend for future IHS National Clinical Rounds?

7. Certificate Information:
Thank You for completing this survey. Click the link below for the appropriate certificate.
If you are requesting certificate of completion, please click here for your certificate.
If you have difficulty please contact Alaina George at alaina.george@ihs.gov .