

DBHDID TRAINING EVENT EVALUATION FORM

| | | | | |
|--------|-----------|-----------|--|--|
| Title: | | | | |
| Date: | Duration: | Location: | | |

OBJECTIVES

| | | | | | |
|---|----------------|-------|----------|-------------------|----------------|
| I achieved each of the following objectives | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Applicable |
| 1. | 4 | 3 | 2 | 1 | N/A |
| 2. | 4 | 3 | 2 | 1 | N/A |

PRESENTER(S)

| Presenter Name | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Applicable |
|--------------------------|----------------|-------|----------|-------------------|----------------|
| Presenter #1 | | | | | |
| Well prepared | 4 | 3 | 2 | 1 | N/A |
| Knowledgeable of subject | 4 | 3 | 2 | 1 | N/A |
| Responsive to questions | 4 | 3 | 2 | 1 | N/A |
| Presenter #2 | | | | | |
| Well prepared | 4 | 3 | 2 | 1 | N/A |
| Knowledgeable of subject | 4 | 3 | 2 | 1 | N/A |
| Responsive to questions | 4 | 3 | 2 | 1 | N/A |
| Presenter #3 | | | | | |
| Well prepared | 4 | 3 | 2 | 1 | N/A |
| Knowledgeable of subject | 4 | 3 | 2 | 1 | N/A |
| Responsive to questions | 4 | 3 | 2 | 1 | N/A |
| Presenter #4 | | | | | |
| Well prepared | 4 | 3 | 2 | 1 | N/A |
| Knowledgeable of subject | 4 | 3 | 2 | 1 | N/A |
| Responsive to questions | 4 | 3 | 2 | 1 | N/A |
| Presenter #5 | | | | | |
| Well prepared | 4 | 3 | 2 | 1 | N/A |
| Knowledgeable of subject | 4 | 3 | 2 | 1 | N/A |
| Responsive to questions | 4 | 3 | 2 | 1 | N/A |
| Presenter #6 | | | | | |
| Well prepared | 4 | 3 | 2 | 1 | N/A |
| Knowledgeable of subject | 4 | 3 | 2 | 1 | N/A |
| Responsive to questions | 4 | 3 | 2 | 1 | N/A |

CONTENT

| | | | | | |
|---|----------------|-------|----------|-------------------|----------------|
| | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Applicable |
| Written description consistent with actual presentation | 4 | 3 | 2 | 1 | N/A |
| Relevant to my needs | 4 | 3 | 2 | 1 | N/A |
| Length of time suitable | 4 | 3 | 2 | 1 | N/A |
| Level appropriate for my knowledge base | 4 | 3 | 2 | 1 | N/A |
| Handouts useful | 4 | 3 | 2 | 1 | N/A |

FACILITY

| | | | | | |
|----------------------------|----------------|-------|----------|-------------------|----------------|
| | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Applicable |
| Location easy to access | 4 | 3 | 2 | 1 | N/A |
| Room conducive to learning | 4 | 3 | 2 | 1 | N/A |
| Facility staff helpful | 4 | 3 | 2 | 1 | N/A |

***Please complete both sides of this evaluation form**

OVERALL

| Please rate the following | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Applicable |
|--|----------------|-------|----------|-------------------|----------------|
| Pre-registration process was organized and efficient | 4 | 3 | 2 | 1 | N/A |
| On-site registration process was organized and efficient | 4 | 3 | 2 | 1 | N/A |
| Session met my overall expectations | 4 | 3 | 2 | 1 | N/A |
| Would recommend this session to others | 4 | 3 | 2 | 1 | N/A |

Describe the most helpful aspects of this session

Please share any suggestions for improving this session

Please list topics for future trainings you would like to attend

DEMOGRAPHICS

Please check your **primary** function as related to this training event—check only one

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Administrator/Manager <input type="checkbox"/> Advocate <input type="checkbox"/> Alcohol & Drug Counselor <input type="checkbox"/> Certified Case Manager <input type="checkbox"/> Consumers <input type="checkbox"/> Data/Info System Specialist <input type="checkbox"/> Direct Support Professional <input type="checkbox"/> Educator <input type="checkbox"/> Family Member <input type="checkbox"/> Financial Manager <input type="checkbox"/> Marriage and Family Therapist <input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Administrator | <ul style="list-style-type: none"> <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Pastoral Counselor <input type="checkbox"/> Physician <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Professional Art Therapist <input type="checkbox"/> Professional Counselor <input type="checkbox"/> Recreational Therapist <input type="checkbox"/> Rehabilitation Counselor <input type="checkbox"/> Self Advocate <input type="checkbox"/> Speech-Language Pathologist and Audiologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Other |
|---|--|

Please check your agency –check only one

- Advocacy Group
- College/University
- Community Mental Health Center
- Private Provider-*Community Based*
- Private Provider-*Hospital*
- School-*Local District*
- State Government-*Central Office*
- State Government-*Local Office*
- State Operated Facility
- Other

Please give name of agency

COMMENTS

Thank you for completing this evaluation.