

University of California, Davis, Health System - Office of Continuing Medical Education (OCME)
ONLINE CME Registration and Evaluation Form / Fax completed form to: (916) 734- 0776

CME Self Study Module: _____

Date Created: _____ OCME Course Code: _____

DATE VIEWED EVENT: _____ **Please fill-out the yellow shaded areas prior to printing form.**

Name (First Last): _____ **Degree:** _____

Occupation: _____ **Specialty (Physician only)** _____ **Social Security # XXX – XX -** _____
 ("Other" only) _____ (Last 4 digits – for transcript purposes only)

Mailing Address: Agency (Optional) _____

Street: _____

Suite/Apt _____

City: _____

State/Providence: _____ **USA (or Other** _____ **) Zip/Postal Code:** _____

Day time phone number: () _____ - _____

Email (Optional) _____

I have reviewed the CME Disclosure Statement YES NO

EVALUATION: (Check your answer 5=strongly agree 1=strongly disagree)

- | | | | | | |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1. The material was practical and included useful information | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| 2. My time at the program was well spent. | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| 3. The program met its objectives. | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| 4. I found this presentation to be free from bias. | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| 5. Issues in cultural and linguistic competency were adequately addressed in this activity?
(e.g. differences in prevalence, diagnosis, treatment in diverse population; linguistic skills; pertinent cultural data) | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |

6. What percent of the material was new to you? 100 90 80 70 60 50 40 30 20 10 0

7. What information or techniques did you acquire that you plan to use in your practice?

8. Resources on cultural and linguistic competency are available on our website at cme.ucdavis.edu under AB1195. How can we further meet your educational needs in this area?

9. What topics would you suggest for future programs?

10. Additional comments:

Thank you for completing this form. If you have questions, please call 916-734-5390.

Disclosure

LECTURE
SPEAKER NAME
DATE OF PRESENTATION

Disclosure of Faculty Relationships: As a sponsor accredited by the Accreditation Council for Continuing Medical Education, the UC Davis Health System Office of Continuing Medical Education must insure balance, independence, objectivity, and scientific rigor in all its individually sponsored or jointly sponsored educational activities. All faculty participating in a sponsored activity are expected to disclose to the activity audience any significant financial interests or other relationships with the 1) manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in an educational presentation, and 2) any commercial supporters of the activity (significant financial interests or other relationships can include grants or research support, employee, consultant, stock holder, member of speakers bureau, etc.). The intent of this disclosure is not to prevent speakers with significant financial or other relationships from making presentations, but rather to provide listeners with information on which they can make their own judgments. It remains for the audience to determine whether the speaker's interests or relationships may influence the presentation with regard to exposition or conclusion.

The following have indicated no financial interest/affiliation that may affect presentations:

The following have indicated financial interest or affiliation:

NAME	COMMERCIAL INTEREST & NATURE OF RELATIONSHIP
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The following have not indicated financial interest or affiliations that may affect presentations, but will give their disclosure at the beginning of their presentation(s).

Speakers will support their lecture and clinical recommendations with the "best available evidence" from the medical literature.

Accreditation Information

ACCREDITATION The University of California, Davis, Health System is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Physician Credit: The Office of Continuing Medical Education of the University of California, Davis, Health System (School of Medicine, Medical Center and Medical Group) designates this enduring material for a maximum of _____ **AMA PRA Category 1 Credit(s)**[™]. Physicians must complete the entire course to qualify for credit; there is no "partial credit" allowed for this study. This program is accredited for a two year period from the original release date of _____.

Physician Assistant: The National Commission on Certification of Physician Assistants (NCCPA) states that AMA accredited Category 1 courses are acceptable for continuing medical education requirements for recertification.

Registered Nurse: The California Board of Registered Nursing accepts CME Category 1 credit toward license renewal. On the BRN license renewal form, report the number of hour(s) you attended and fill in "CME Category 1 Credit". Credit for this event is up to _____ hour(s) of credit.

Please note that all pertinent information for this program is located for review at OCME, 3560 Business Drive, Suite 130, Sacramento, CA 95820