

**EVALUATION**

1. Did this workshop meet your expectations? YES NO  
If no, explain.

2. Objectives:	BEFORE you took this course	AFTER you took this course
<b>Please rate your ability to:</b>		
a. Identify a minimum of two statutory or regulatory policies regarding the provisions of health adolescent women in Missouri,	Poor Average Good Great Excellent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor Average Good Great Excellent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
b. Discuss the practice implications of selected policies targeting adolescent health; in particular the reporting process for adolescent sexual abuse in Missouri,	Poor Average Good Great Excellent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor Average Good Great Excellent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
c. Describe a minimum of two policies related to intimate partner violence among adolescent women in Missouri.	Poor Average Good Great Excellent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor Average Good Great Excellent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
d. Identify scope of problem, safety planning, reporting and orders of protection.	Poor Average Good Great Excellent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor Average Good Great Excellent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**3. CONTENT AND PROCESS EVALUATION**

- a. The teaching methods used were effective in assisting me to learn the content.
- b. Audiovisual material and/or handouts were an asset to my learning.
- c. The content of this program was relevant to my learning needs.
- d. I will be able to use the content presented at my place of employment.

	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree

**4. PLEASE PRIORITIZE (from 1 = High to 5 = Low) THE REASONS YOU CHOSE TO ATTEND:**

\_\_\_\_\_ Program Content    \_\_\_\_\_ Specific speaker(s)    \_\_\_\_\_ To earn Contact Hours  
\_\_\_\_\_ Location    Other: \_\_\_\_\_

**5. PLEASE RATE THE SPEAKER(S) ON EACH OF THESE CHARACTERISTICS USING THE FOLLOWING SCALE:**

0 = Not Applicable    1 = Excellent    2 = Good    3 = Average    4 = Poor

**Sue Kendig**

a. Knowledge of subject	
b. Organization and clarity of content	
c. Ability to stimulate interest and discussion	
d. Balanced amount of theory and practical application	

**6. ONE THING THAT I WOULD CHANGE ABOUT THIS WORKSHOP IS:**

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**7. REGISTRATION & PROGRAM ACCESSIBILITY:**

	YES	NO
a. Registration process was efficient.		
b. Webinar was easy to access and use.		
c. Promotional information (brochure) provided adequate information.		

**8. COMMENTS/SUGGESTIONS REGARDING THE WEBINAR:**

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**9. ONE THING I PLAN TO DO DIFFERENTLY BECAUSE OF THIS WORKSHOP IS:**

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**10. DID THE INDIVIDUAL OBJECTIVES RELATE TO THE OVERALL PURPOSE/GOALS OF THE ACTIVITY?**

YES                      NO

**11. WHAT SPECIFIC INFORMATION OR SKILLS WILL YOU BE ABLE TO USE FROM THIS TRAINING IN YOUR TRAINING?**

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**12. WHAT ADDITIONAL PRESENTATION TOPICS WOULD HAVE BEEN HELPFUL?**

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**13. ADDITIONAL COMMENTS?**

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Thank you!

**Missouri Webinar**  
**Policy & Practice: Adolescent Issues in Reproductive Health**  
**NURSING CONTACT HOURS FORM**

The evaluation and request for credit must be completed appropriately and submitted to staff at Development Systems, Inc. before any certificate of CE's is issued to the participant.

***Please print requested information.***

**Name (as it appears on license)** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Nursing License State/Number:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Home City/State/Zip:** \_\_\_\_\_

*By signing and dating this form, you are certifying you attended the training session indicated above in its entirety and are entitled to receive contact hours.*

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

*Development Systems, Inc., is an approved provider of continuing nursing education by the Missouri Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.*