Program: "Addressing Cultural Competency: A Novel Curriculum for Pediatric and Child Psychiatry Residents"
Date: June 19, 2015
Speaker: Kimberly Ann Gordon, MD

Your comments are very important to us!
Please complete this evaluation so that we may provide more quality programs in the future.

The therapeutic recommendations presented in this activity did not encourage inappropriate or excessive use of products/devices.  Agree             Disagree

The information presented in this activity did not serve to advance a proprietary interest of any commercial entity.  Agree             Disagree

**Expected Clinical Outcomes**
1. Will information gained from this program result in enhancing optimal patient care?  Yes             No
2. If yes, please list change(s) you intend to make in your practice as a result of this program.
3. Please rate your confidence in implementing these changes.

<table>
<thead>
<tr>
<th>High confidence</th>
<th>Moderate confidence</th>
<th>Low/No confidence</th>
<th>N/A</th>
</tr>
</thead>
</table>
4. Please identify any barriers you perceive in implementing these changes (select all that apply)
   - Cost
   - Lack of time to assess/counsel patients
   - Lack of administrative support/resources
   - Insurance/reimbursement issues
   - Patient compliance issues
   - Lack of consensus of professional guidelines
5. How will you address these barriers to implement changes in knowledge and behavior?

**Basic Program Evaluation**
5 = Excellent / 4 = Good / 3 = Average / 2 = Fair / 1 = Poor
6. The material was presented at an appropriate level.  5 4 3 2 1
7. I have gained knowledge that will improve patient care.  5 4 3 2 1
8. The program met my expectations in accomplishing the stated educational objectives.  5 4 3 2 1
9. Your overall rating of the quality of the education offered at this program.  5 4 3 2 1

10. Additional Comments/Explanations:
11. How can this program be improved? (Please list both strengths and weaknesses.)
12. Based on your educational needs, please provide us with suggestions for future program topics and formats:

Thank you for your feedback!
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Please print legibly

Fill this form out completely for a RECORD of your attendance to this lecture

________________________________________
Full Name (PRINTED)

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State License Number

You MUST include your license number to receive credit

Please circle your title

MD   DO   PhD   LCSW   LMHC   LMFT   ARNP
      RN   LPN

Medical Student   Resident
Fellow   Psy.D.   Faculty   Other: ____________

Please circle what type of credit is needed:   CME   CE   CEU

This form MUST be completed and return by 5pm the day of the presentation to:

Attn: Debra Krawczykiewicz  debra@ufl.edu  or 352-265-7983 (fax)