



Accredited Continuing Education Activity Evaluation

Activity Title: _____

Speaker(s): _____

Date: _____

I am a: MD DO RN ARNP PA Student Other: _____

1. After attending this program, I plan to make the following changes to my practice (*check all that apply*)

- a. Modify Treatment Plans
- b. Change Screening/Prevention practice
- c. Incorporate different diagnostic strategies into patient evaluation.
- d. Use alternative communication methodologies with patients & families.
- e. Other: enter specifics here: _____

2. This program will help me improve my practice in the following areas (*check all that apply*):

- Knowledge
- Competence
- Performance

Comments:

Please suggest further topics or speakers:

CERTIFICATION STATEMENT

Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**I Certify that I attended this Accredited Continuing Education Activity and claim
_____ AMA PRA Category 1 Credit(s)™:**

Name & Degree _____

Email: _____

*This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Medical Association of Georgia through the joint providership of Southern Alliance for Physician Specialties CME and _____.
The Southern Alliance for Physician Specialties CME is accredited by the Medical Association of Georgia to provide accredited continuing education for physicians.*