

**Child Health and Disability Prevention (CHDP) Program
 State of California CMS/CHDP
 Department of Health Care Services**



**Play Audiometry Screening Training
 Evaluation Form**

Training Date: _____

Home Clinic: _____

Note: On scale 1-4, 4 being the best, please rate the below.

TRAINING FACILITATOR	Poor	Fair	Good	Excellent
Name:				
Facilitation	1	2	3	4
Knowledge	1	2	3	4
Presentation	1	2	3	4
Name:				
Facilitation	1	2	3	4
Knowledge	1	2	3	4
Presentation	1	2	3	4
Name:				
Facilitation	1	2	3	4
Knowledge	1	2	3	4
Presentation	1	2	3	4
TRAINING CONTENT	Strongly Disagree	Disagree	Agree	Strongly Agree
I was well informed about the objectives of this workshop	1	2	3	4
The training materials provided were useful	1	2	3	4
The contents were relevant	1	2	3	4
TRAINING RESULTS	Strongly Disagree	Disagree	Agree	Strongly Agree
The program met my expectations	1	2	3	4
I will be able to use what I learned in this training	1	2	3	4

Comments:

Completion of this evaluation is needed to receive a certificate of attendance.