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



Vision 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	Agree	Strongly	
TRAINING CONTENT	Disagree	Disagree	Agree	Agree	
I was well informed about the	1	2	3	4	
objectives of this workshop	1	2	3	4	
The training materials provided	1	2	3	4	
were useful	1	2		7	
The contents were relevant	1	2	3	4	
TRAINING RESULTS	Strongly	Disagree	Agree	Strongly	
INAMMO RESULTS	Disagree	Disagree	Agree	Agree	
The program met my expectations	1	2	3	4	
I will be able to use what I learned in	1	2	3	4	
this training	1	2	3		

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