Gap Assessment Survey

2017 GAP ASSESSMENT SURVEY

This survey is to help us gather data to measure how this program did in meeting the established gap. Your information will help us plan for next year’s meeting.

Thank you in advance for your participation.

* - indicates a required item.

After attending this program, did the knowledge you gained help you make any changes in (select all the apply):

Your Competence?

☐ Yes  ☐ No

If yes, please explain:

Characters Left: 500

Your Performance?

☐ Yes  ☐ No

If yes, please explain:

Characters Left: 500

Your Patient Outcomes?

☐ Yes  ☐ No

If yes, please explain:

Characters Left: 500

* Did you run into any barriers which affected your ability to make changes?
Yes  No

If yes, why?

Can you identify any problems in practice/patient care which you would like to see addressed at a future meeting?