

## e-Training Evaluation Form

**Title of Training:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Please provide us with an honest assessment of this e-training. Your input will help to improve the quality of this training. Please explain any fair or poor ratings. This form must be completed and returned to the Administrative Coordinator at MOPS before you may receive a certificate of participation (required for receiving CEU's).**

**PLEASE BE SURE TO ANSWER ALL THE QUESTIONS.**

<b>CONTENT</b>	<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
<b>Organization: How coherent and well developed was the content? Did it follow logically?</b>					
<b>Thoroughness: How well did the content cover the topic area?</b>					
<b>Method: How appropriate was this method of presentation of the content? Was the e-Training effective in presenting the materials?</b>					
<b>Comments:</b>					
<b>RELEVANCE</b>	<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
<b>To what degree was the content appropriate to meet your assessed job training needs?</b>					
<b>To what degree was the content appropriate for your skill level?</b>					
<b>Comments:</b>					
<b>UNDERSTANDING</b>	<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
<b>What was your level of understanding of the topic prior to the training?</b>					
<b>What is your level of understanding now?</b>					
<b>Comments:</b>					
<b>What benefits have you received from attending the session?</b>					

**Is there anything else you would like to contribute regarding the training?**

**What other trainings would you like this agency to provide?**

Your Name: \_\_\_\_\_

e-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

License (circle all that apply and enter your license number):

Professional Counselor # \_\_\_\_\_

Professional Clinical Counselor # \_\_\_\_\_

Licensed Social Worker # \_\_\_\_\_

Licensed Independent Social Worker # \_\_\_\_\_

Psychologist # \_\_\_\_\_