

## Evaluation Form

Course Sponsor: Smith Seminars  
Course Title: Caring for Patients from Different Cultures

### Part 1: Teaching Effectiveness of the Presenter(s)

Please rate the teaching effectiveness of the presenters using the scale below:

1 = Poor    2 = Fair    3 = Good    4 = Excellent    5 = Superior

Presenters (in program order)	Teaching Effectiveness			
	Organization	Delivery	Content	Audio Visual
<b>Coarse Overview</b> Debra Smith, RRT, RCP				
<b>Caring for Patients from Different Cultures</b> Debra Smith, RRT, RCP				

### Part 2: Your Achievement of Educational Objectives

Please rate the degree to which you believe you achieved the educational objectives for each module by placing a check mark in the appropriate box corresponding to each:

Objectives for each module	I achieved this activity's educational objectives			
	Strongly Agree	Agree	Disagree	Strongly Disagree
<b>Caring for Patients from Different Cultures</b> <ol style="list-style-type: none"> <li>1. Define culture, stereotype, and generalization of groups.</li> <li>2. Identify the factors of prejudice and discrimination.</li> <li>3. Define values, world view, and emic and etic.</li> <li>4. Identify the concepts of ethnocentrism and cultural relativism, and time orientation.</li> <li>5. List the beliefs of cultures about food, disease, and pain.</li> <li>6. Define the cultural factors about staff relations, death and dying, mental health, folk medicine.</li> </ol>				

### Part 3: Program Integrity

Indicate your agreement with the following statement by checking the appropriate response:

**The content of this course was presented without bias of any commercial product or drug**

**Strongly Agree** \_\_\_\_\_ **Agree** \_\_\_\_\_ **Disagree** \_\_\_\_\_ **Strongly Disagree** \_\_\_\_\_

Comment:

Print the Evaluation Form, answer the questions, and fill out personal information.

Submission Method #1 – Fax to us at 972-759-9791

Submission Method #2 - Smith Seminars, PO Box 516, Paradise, TX 76073

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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

Order Confirmation Number: \_\_\_\_\_

AARC member number \_\_\_\_\_

Licensure State \_\_\_\_\_