

## Evaluation Form

Course Sponsor: Smith Seminars  
Course Title: Respiratory Disorders in Neonates and Infants

### 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, CRT, RCP				
<b>Respiratory Disorders in Neonates and Infants</b> Debra Smith, RRT, CRT, 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>Respiratory Disorders in Neonates and Infants Objectives</b> 1. List the causes of respiratory distress in neonates and infants 2. Summarize the factors of apnea in the premature infant 3. Identify factors of bronchopulmonary dysplasia & meconium aspiration 4. Explain the etiology, diagnosis, pathophysiology, prognosis, and treatment of persistent pulmonary hypertension, respiratory distress syndrome, transient tachypnea, children with chronic health conditions, death and dying, and the sick neonate				

### 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 \_\_\_\_\_