

## RESQCPR SYSTEM STUDENT COURSE EVALUATION

Organization: \_\_\_\_\_

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

Instructor(s): \_\_\_\_\_

Please complete this course evaluation. The information you provide will be treated in confidence and will help us in planning future courses. Circle the number that best matches your opinion on the statement.

	Strongly DISAGREE	DISAGREE	NEUTRAL	AGREE	Strongly AGREE
I felt confident in my knowledge of the ResQCPR System <b>BEFORE</b> the course.	1	2	3	4	5
I feel confident in my knowledge of the ResQCPR System <b>AFTER</b> the course.	1	2	3	4	5
I felt confident in my ability to perform ResQCPR <b>BEFORE</b> the course.	1	2	3	4	5
I feel confident in my ability to perform ResQCPR <b>AFTER</b> the course.	1	2	3	4	5
The course met the stated objectives.	1	2	3	4	5
The instructor(s) communicated clearly.	1	2	3	4	5
The instructor(s) answered all my questions.	1	2	3	4	5
The method of training was effective.	1	2	3	4	5
I would recommend this course to others.	1	2	3	4	5
I found this course to be beneficial.	1	2	3	4	5

**This course was:**     Mandatory                       Optional

**What is your level of training? (check ALL that apply)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Healthcare educator | <input type="checkbox"/> EMT – Paramedic   | <input type="checkbox"/> Respiratory therapist |
| <input type="checkbox"/> First responder     | <input type="checkbox"/> Nursing assistant | <input type="checkbox"/> Physician             |
| <input type="checkbox"/> EMT – Basic         | <input type="checkbox"/> LPN               | Other (state): _____                           |
| <input type="checkbox"/> EMT – Intermediate  | <input type="checkbox"/> RN                |  |

What did you like best about the course? \_\_\_\_\_

\_\_\_\_\_

What would you change about the course to make it better? \_\_\_\_\_

\_\_\_\_\_

Comments (use back if necessary): \_\_\_\_\_

\_\_\_\_\_