UCLA Office of Continuing Medical Education
CME Certificate Address Verification Form

Ophthalmic Clinical Conference

NAME: _____ LAST 4 DIGITS OF SSN: _____
please print clearly degree

ADDRESS: _____

_____

PHONE: _____ FAX: _____

E-MAIL: _____

On a scale of 1 – 5 (5 = "strongly agree" and 1 = "strongly disagree"), please respond to the following statements:

1) The information learned during this program is likely to have an impact on my practice. ___

2) This program taught me new important information and/or verified important information for me. ___

CME SURVEY:

1. What is your specialty? _____

2. Which of the following best describes your practice status?

   _____ Fee-for-service private practice (i.e. solo, partnership, multi-specialty)

   _____ Full-time academic

   _____ Salaried employee (i.e. HMO)

   _____ Institutional (i.e. military, VA, hospital-based)

   _____ Retired or semi-retired

   _____ Other (please specify) _____

3. What areas would you like to see covered in future CME programs produced by UCLA?

4. Would you be interested in UCLA developing courses focusing on basic science concepts as they relate to evolving clinical areas, (human genetics, molecular biology, etc.)?

5. Speaking for your specialty, do you believe that there is a need for the presentation of an annual, updated version of this program?

TO RECEIVE CME CREDIT THIS FORM MUST BE COMPLETED AND RETURNED TO:

Debbie Sato
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200 Stein Plaza, Rm 2-316
Los Angeles, CA 90095
Phone (310) 825-4617
FAX (310) 206-8015