

Sudden Infant Death Syndrome Training Evaluation

TYPE OF TRAINING

LOCATION

MONTH, DAY, YEAR

I am a/an:

- Expectant/New Parent Physician RN/PHN Childcare Provider
 Firefighter/EMT/Paramedic Police Officer/Sheriff Medical Examiner/Coroner Social Worker
 Administrator Health Educator Mortuary Professional Clergy
 Other (Please List): _____

Please answer these questions. Your responses will help us improve our training. Use the reverse side if you need more space. Circle the response that most closely applies.

Please rate the training based on the following:

	Excellent			Poor	
! Usefulness of information	5	4	3	2	1
! Relevance to your work setting	5	4	3	2	1
! Quality of materials	5	4	3	2	1
! Overall evaluation	5	4	3	2	1

What did you find the **most useful** about the session? _____

What was the **least useful** about the session? _____

Have you any comments or suggestions to help us improve this training? _____

Do you feel the materials provided are culturally appropriate? ___ Yes ___ No If No, please explain below:

Are you aware of a specific audience that may benefit from a SIDS training? ___ Yes ___ No

If yes, please list name of organization/agency: _____

Address: _____ Phone: (_____) _____

Contact Person: _____ Email: _____

Thank you.