

CME REGISTRATION AND EVALUATION FORM

Evidence-Based Review of the Treatment of Painful Cervical Dystonia

CME Registration *(Please print)*

Name/Degree _____

Specialty _____

Address _____

City _____

State _____ Zip _____

E-mail Address _____

Date _____

I certify that I have completed this CME activity as designed

I am claiming that I participated in _____ credit hour of this CME activity (maximum for this activity is 1 hour).

Signature _____ Date _____

Evaluation: *Please evaluate the effectiveness of this CME activity on a scale of 1 to 5, with 1 being the LOWEST, and 5 being the HIGHEST by circling your choice.*

1. Overall quality of this CME/CE activity	1	2	3	4	5
2. Content	1	2	3	4	5
3. Format	1	2	3	4	5
4. Faculty/Speakers	1	2	3	4	5
5. Achievement of educational objectives	1	2	3	4	5

6. This CME activity provided a balanced, scientifically rigorous presentation of therapeutic options related to the topic, without commercial bias.

1 2 3 4 5

Comments _____

7. Please comment on the impact (if any) that this CME activity might have on your practice.

8. Additional comments and/or suggested topics for future CME activities?

To receive CME credit, please return this form to IMS, 14 Monarch Bay Plaza, #202, Monarch Beach, CA, 92629