

TRAINING PROGRAM EVALUATION FORM

For completion by training participants.

Be sure to complete any additional evaluation required by your residency or program.

Name: _____ Residency _____
 PGY: _____ Date: _____

I. Please evaluate the following aspects of your rotation training experience by circling the appropriate response:

	Poor	Satisfactory	Good	Excellent	Outstanding	Did not experience
a Didactic teaching	1	2	3	4	5	N/A
b Syllabus	1	2	3	4	5	N/A
c Clinic orientation	1	2	3	4	5	N/A
d Abortion counseling experience	1	2	3	4	5	N/A
e Medical screening/management	1	2	3	4	5	N/A
f Pelvic examination / sizing	1	2	3	4	5	N/A
g Pain management techniques.	1	2	3	4	5	N/A
h Vacuum aspiration technique	1	2	3	4	5	N/A
i Use of ultrasound	1	2	3	4	5	N/A
j Routine post-abortion care	1	2	3	4	5	N/A
k Opportunities to ask questions	1	2	3	4	5	N/A
l Opportunities to interact with clinic staff	1	2	3	4	5	N/A
m Initial Program Orientation (didactic session at residency)	1	2	3	4	5	N/A

2. What did you like most about the training?

3. What did you like least about the training?

4. In your opinion, the length of your training was:

- adequate
- too short
- too long

5. Did the abortion training rotation adequately prepare you to:

a Counsel patients about pregnancy options	Yes	No, need more
b Counsel patients choosing abortion	Yes	No, need more
c Counsel patients about contraceptive options	Yes	No, need more
d Obtain informed consent for abortion	Yes	No, need more
e Perform accurate pelvic sizing	Yes	No, need more
f Perform aspiration procedures under local anesthesia	Yes	No, need more
g Perform 1st trimester aspiration abortions with confidence	Yes	No, need more
h Manage common abortion complications	Yes	No, need more
i Integrate abortion with other health services in your regular practice	Yes	No, need more

6. What additional abortion training opportunities would you like your residency program to provide, if any?

7. Please evaluate the following training faculty by circling the appropriate responses:

Name of Trainer	Poor	Satisfactory	Good	Excellent	Outstanding	Did not experience
	1	2	3	4	5	NA
	1	2	3	4	5	NA
	1	2	3	4	5	NA
	1	2	3	4	5	NA
	1	2	3	4	5	NA
Other:	1	2	3	4	5	NA

8. What are your immediate career plans following graduation from this residency program?

9. What are your long-term career plans?

10. Where do you hope to practice after graduating from this residency program?

- In this state
- In another US state (specify: _____)
- Outside the US (specify: _____)
- Don't know yet

11. Do you plan to pursue additional abortion training during or after your residency? If "Yes," what additional training? _____ _____	Yes	No	Undecided
12. Do you anticipate providing aspiration abortions in your post-residency practice?	Yes	No	Undecided
13. Do you anticipate providing early medication abortions (mifepristone or methotrexate) in your post-residency practice?	Yes	No	Undecided

14. Since completing the abortion training rotation, has your interest in or commitment to providing abortion services:

- Increased
- Decreased
- Remained the same

15. Has the abortion training rotation influenced your attitudes or opinions about abortion in any positive or negative way? Please explain:

16. What suggestions do you have for improving the training program?

17. Other comments: