Mouth Care Without a Battle©

Individualized Mouth Care for Persons with Cognitive and Physical Impairment

This continuing nursing education activity was approved by the North Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

To receive credit for program completion, complete the evaluation below, being sure to completely fill in your name, address, and level of training. Then, send the completed form with a $5.00 processing fee (check or money order payable to Mouth Care Without a Battle) to:

Mouth Care Without a Battle©
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill
725 Martin Luther King Jr., Blvd. CB 7590
Chapel Hill, NC 27599-7590

Following successful processing of your form, a certificate of completion will be mailed to you at the address provided, usually within 2 weeks. If you completed more than one module, complete a separate form for each module, and mail all forms in together. You need to pay only $5.00 regardless of the number of modules you complete.

Check each of the modules that successfully completed by watching the entire module:
Module 1 ☐ Module 2 ☐ Module 3 ☐

Please tell us how you rate this program in each of the following areas:

		Poor	Fair	Good	Very Good	Excellent
1.	Overall program content	☐	☐	☐	☐	☐
2.	Overall program appearance	☐	☐	☐	☐	☐
3.	Appropriateness of the program to your experience level	☐	☐	☐	☐	☐
4.	How well the program met your needs	☐	☐	☐	☐	☐
5.	Overall satisfaction	☐	☐	☐	☐	☐

		No	Yes
6.	Did you learn new techniques for providing daily mouth care?	☐	☐
7.	If yes, will what you learned in the program change how you provide daily mouth care?	☐	☐
8.	Did you learn techniques for providing mouth care to people who may be resistive to care?	☐	☐
9.	If yes, will you use these techniques to provide mouth care to people who may be resistive?	☐	☐
10.	Would you recommend this program to someone else in your position?	☐	☐

10. What was the <u>most</u> valuable part of this training program for you?

11. What was the <u>least</u> valuable part of this training program?

12. How can this program be improved?

Your name (please print): _____

Your address: _____

Your training (check one): □ **Nursing assistant** □ **Licensed practical nurse** □ **Registered nurse**
□ **Other (please specify)** _____