



## Continuing Education Program Evaluation Form

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Program title:

Program date(s) and time(s):

Program locations(s):

Program provider (Organization, Company, Health District, etc.):

Address:

Contact Person:

Title/Department:

Address:

Telephone:

Fax:

Email:

Program sponsor (if different):

Evidence of participation by pharmacists will be provided by (check one):

- Learning Project Record – Accredited Live CE Program  
(To be filled out by the attending pharmacist & placed in their Learning Portfolio)
- Marked Post-Test

If printed program material is attached and contains the following information, these sections can be marked therein. Otherwise, when filling in the sections below, use additional pages as required. Please send a copy of any handouts for participants when available.

Program presenter(s) and their qualifications (mini CV):

Length/schedule of program. (Please list the Q & A length as well):

Program audience:

Program Learning Objectives:

Program outline of discussion:

**Please return this completed form and any other additional information (flyer/brochure, slide presentation, handouts, presenter's full CV, etc.) to:**

Continuing Professional Development for Pharmacy Professionals  
**College of Pharmacy and Nutrition, University of Saskatchewan**  
2A20.34 Health Science Building – 104 Clinic Place, Saskatoon SK S7N 2Z4  
Telephone: (306) 966-6350, Email: [danielle.larocque@usask.ca](mailto:danielle.larocque@usask.ca)

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**For Office Use Only:**

Date Received: \_\_\_\_\_ # of CEUs Approved: \_\_\_\_\_

Date of Approval: \_\_\_\_\_ Approved by: \_\_\_\_\_

File Number: \_\_\_\_\_