

Form 7: New and Expectant Mothers Essential Skills Training Program Evaluation

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor's Name: \_\_\_\_\_

Where did you hear about this program? \_\_\_\_\_

Did you learn what you were hoping to learn from this program? Yes\_\_\_ No\_\_\_

Will you be using this information in the future? Yes\_\_\_ No\_\_\_

If Yes, How will you be using it?

\_\_\_\_\_

Did the instructor know the material? Yes\_\_\_ No\_\_\_

Was the room comfortable? Yes\_\_\_ No\_\_\_, if not, how could we make it more comfortable?

\_\_\_\_\_

Was there enough variety in learning styles, like power point, handouts, personal touches, etc.?

Yes\_\_\_ No\_\_\_

What could we change to make this program better?

\_\_\_\_\_

Are you interested in taking future courses? Yes\_\_\_ No\_\_\_

If yes, which courses/workshops would you like to take?

\_\_\_\_\_

\_\_\_\_\_

Other comments or suggestions

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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OFFICE USE:

Volunteer Hours:\_\_\_\_\_ Total Hours:\_\_\_\_\_ Referral Out:\_\_\_\_\_

Barriers (if any):\_\_\_\_\_

Self Confidence: Low\_\_\_\_\_ Medium\_\_\_\_\_ High \_\_\_\_\_

Improved\_\_\_\_\_

Completion: successful:\_\_\_\_\_ needs improvement:\_\_\_\_\_

Post Program:\_\_\_\_\_