

**Stroke Network of Southeastern Ontario
Professional Education Stroke Fund**

**Shared Work Experience
Education Support Programs**

Evaluation Form

(Updated September 2011)

This evaluation must be completed by **each** participant. Please **circle** whether you are Participant 1 (person who initiated the experience) or Participant 2 (person who was contacted).

Name of Participant 1:

Or

Name of Participant 2:

Location of learning experience:

Date of learning experience:

Please list the learning objectives that you stated on your application form.

1. _____
2. _____
3. _____

Please state specific answers to the following questions.

1. Were these objectives met? (circle)

Objective 1	Yes	No	Partially
Objective 2	Yes	No	Partially
Objective 3	Yes	No	Partially

2. Please state any barriers you encountered in meeting these objectives.

Objective 1 _____

Objective 2 _____

Objective 3 _____

3. What facilitated your meeting these objectives?

Objective 1 _____

Objective 2 _____

Objective 3 _____

4. Was this learning experience worthwhile?

5. Were there any unexpected learning opportunities that arose from this Shared Work Experience?

6. Please list any comments you might have from this experience.

Thank you for completing this evaluation. Please return to:

Charlette Campbell, Administrative Assistant
Stroke Network of Southeastern Ontario
Kingston General Hospital, Doran 3, Rm 313
76 Stuart St.
Kingston, ON K7L 2V7
Fax: 613-548-2454

Return within two weeks of the learning experience. Once this evaluation has been returned arrangements will be made to distribute the financial incentive as agreed upon during the application process.