Continuing Medical Education Registration and Evaluation Form

Title of Activity: Child Health Grand Rounds - Approved Duration: July 1, 2016 - June 30, 2017

The Office of Continuing Education, School of Medicine, University of Missouri is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Office of Continuing Education, School of Medicine, University of Missouri designates this live educational activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should only claim the credit commensurate with the extent of their participation in the activity.

Date of Activity: _____________________________

Topic for CME session: _____________________________

Telehealth Site: _____________________________

*Name of Participant: _____________________________

*Address: _______________________________________

E-mail: _______________________________________

*Discipline:

- MD
- Nurse
- Physician Assistant
- DO
- Nurse Practitioner
- Pharmacy
- OT/PT/Speech Therapist
- EMT/Paramedic
- Other: _____________________________

*Were the following learning objectives met?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss current information regarding diagnosis and treatment of pediatric diseases.</td>
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<tr>
<td>Discuss current information regarding epidemiology and pathophysiology of pediatric diseases.</td>
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</tbody>
</table>

Please rate the following:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>This information is likely to have an impact on my practice.</td>
<td></td>
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<tr>
<td>Conflict of Interest Disclosure was made prior to start of activity.</td>
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<td>The Telehealth system was effective in viewing this activity.</td>
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</tbody>
</table>

*What did you learn in this CME activity that you will apply to your practice of medicine?

________________________________________________________________________________________

*What change(s) will you incorporate into your practice as a result of knowledge acquired at this activity?

________________________________________________________________________________________

Please share any comments or suggestions you may have:

________________________________________________________________________________________

*required for CME credit

Return via fax to: Karla Imhoff - 573-882-5666