

Training Evaluation Form

CLIENT PROVIDES FEEDBACK ON THE LEVEL OF SATISFACTION
EXPERIENCED WITH THEIR TRAINING SESSION(S) AND TRAINER.

CLINICAL DEPARTMENT

Training Day Evaluation

Training Title: _____ Training Date: _____

Trainer Name: _____ No. of Trainees: _____

Training Start Time: _____ End Time: _____ Total Hours Trained: _____

Please select the rating for each section based on the following criteria:

(5) excellent (4) good (3) average (2) fair (1) unsatisfactory

Please rate the trainer(s) on the following:

1. Knowledge of product & subject matter. 5 4 3 2 1

2. Ability to explain and illustrate product. 5 4 3 2 1

3. Ability to answer questions knowledgeably. 5 4 3 2 1

Open-ended comments (use back of form if more space is required):

4. What specifically did you find to be the trainer's greatest strengths?

5. What recommendations, if any, would you suggest to the trainer?

Please rate the content and structure of the training:

4. The relevance of information provided. 5 4 3 2 1

5. The structure of the training session(s). 5 4 3 2 1

6. The pace of the training session(s). 5 4 3 2 1

7. The convenience of training session(s). 5 4 3 2 1

8. The relevance of the training materials. 5 4 3 2 1

9. Rate your overall training experience. 5 4 3 2 1

10. Were you satisfied with the training. Yes No

11. Would you book another training. Yes No

12. Do you feel prepared to use product. Yes No

Open-ended comments (use back of form if more space is required):

13. What did you like most about the training session(s)?

14. What, if anything could be improved with regards to the logistics of the training session(s)?

15. Were there any treatments or techniques that you would have liked to have had covered in your training session(s) that were not? (must be specific to training type)

Please provide name, date and signature below:

(each individual trained should complete a separate evaluation form)

Your Name: _____ Business _____

Signature: _____ Date: _____