

Stroke Network of Southeastern Ontario Professional Education Stroke Fund

Shared Work Experience Education Support Programs

Evaluation Form

(Updated Feb 2021)

This evaluation must be completed by <u>each</u> participant. Please <u>circle</u> 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						
•						
	e state specific an					
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 en	countered in m	eeting these objectives.		
Objecti	ve 1					
Obiecti						
0.0,000						
Ohioati						
Objecti	ve 3				<u>_</u>	

1 of 2



3.	What facilitated your meeting these objectives?					
Objectiv	e 1					
Objectiv	e 2					
Objectiv	e 3					
4.	Was this learning experience worthwhile?					
5.	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 Eves, Administrative Assistant Stroke Network of Southeastern Ontario Kingston Health Sciences Centre – Kingston General Hospital site Watkins 3, Rm 4-3-409-0 76 Stuart St. Kingston, ON K7L 2V7 Email: charlette.eves@kingstonhsc.ca 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.