

# Mouth Care Without a Battle<sup>®</sup>

## *Individualized Mouth Care for Persons with Cognitive and Physical Impairment*

This continuing nursing education activity was approved by the North Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

To receive credit for program completion, complete the evaluation below, being sure to completely fill in your name, address, and level of training. Then, send the completed form with a \$5.00 processing fee (check or money order payable to Mouth Care Without a Battle) to:

**Mouth Care Without a Battle<sup>®</sup>**  
**Cecil G. Sheps Center for Health Services Research**  
**University of North Carolina at Chapel Hill**  
**725 Martin Luther King Jr., Blvd. CB 7590**  
**Chapel Hill, NC 27599-7590**

Following successful processing of your form, a certificate of completion will be mailed to you at the address provided, usually within 2 weeks. If you completed more than one module, complete a separate form for each module, and mail all forms in together. You need to pay only \$5.00 regardless of the number of modules you complete.

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### Check each of the modules that successfully completed by watching the entire module:

**Module 1**       **Module 2**       **Module 3**

### Please tell us how you rate this program in each of the following areas:

	Poor	Fair	Good	Very Good	Excellent
1. Overall program content	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Overall program appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Appropriateness of the program to your experience level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How well the program met your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Overall satisfaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				No	Yes
6. Did you learn anything new from this program?				<input type="checkbox"/>	<input type="checkbox"/>
7. If yes, will you be able to apply what you learned?				<input type="checkbox"/>	<input type="checkbox"/>
8. Would you recommend this program to someone else in your position?				<input type="checkbox"/>	<input type="checkbox"/>
9. What was the <u>most</u> valuable part of this training program for you?					
10. What was the <u>least</u> valuable part of this training program?					
11. How can this program be improved?					

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**Your name (please print):** \_\_\_\_\_ **Email address:** \_\_\_\_\_

**Mailing address:** \_\_\_\_\_

**Training (check one):**     **Nursing assistant**     **Licensed practical nurse**     **Registered nurse**  
 **Other (please specify)** \_\_\_\_\_

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