



# Participant Evaluation of ISAKOS Teaching Center

Please complete this evaluation form and return it to the ISAKOS Office at [isakos@isakos.com](mailto:isakos@isakos.com), or via fax to +1.925.807.1199. ALL INFORMATION PROVIDED ON THIS FORM WILL BE KEPT CONFIDENTIAL.

Thank you.

Your Name: \_\_\_\_\_  
First Name Middle Name Last Name Degrees (M.D., Ph.D., etc.)

Address: \_\_\_\_\_  
Street Department/Suite

\_\_\_\_\_ City State/Province ZIP/Postal Code

\_\_\_\_\_ E-mail: \_\_\_\_\_  
Country

Office Tel: (+\_\_\_\_) \_\_\_\_\_ Office Fax: (+\_\_\_\_) \_\_\_\_\_  
Country Code City/Area Code Number Country Code City/Area Code Number

### Physician Type (check one):

\_\_\_ Orthopaedic Surgeon (Also check subspecialty below) \_\_\_ Fellow \_\_\_ Resident  
\_\_\_ Family Practice \_\_\_ PM&R \_\_\_ Other: \_\_\_\_\_

### Subspecialty (check all applicable):

\_\_\_ Joint Replacement \_\_\_ Arthroscopy  
\_\_\_ Shoulder \_\_\_ Knee \_\_\_ Shoulder \_\_\_ Knee  
\_\_\_ Elbow \_\_\_ Ankle \_\_\_ Elbow \_\_\_ Ankle  
\_\_\_ Hip \_\_\_ Wrist \_\_\_ Hip \_\_\_ Wrist  
\_\_\_ Sports Medicine \_\_\_ Upper Extremity

Please indicate if you are a member of any of the following societies:

\_\_\_ AOSSM \_\_\_ AANA \_\_\_ ESSKA \_\_\_ APOSSM \_\_\_ SLARD \_\_\_ WPOA

## Teaching Center Information

NAME OF TEACHING CENTER: \_\_\_\_\_

CLINICIAN MAINLY RESPONSIBLE FOR TEACHING: \_\_\_\_\_

OTHER CLINICIANS INVOLVED WITH THIS TRAINING: \_\_\_\_\_

DURATION AND DATES OF YOUR TRAINING EXPERIENCE: DURATION: \_\_\_\_\_ MONTHS DATES: \_\_\_\_\_



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## Please describe your experience at this Teaching Center:

### PERCENTAGE OF PROCEDURES PERFORMED:

KNEE SURGERY \_\_\_\_\_%

ARTHROSCOPY: \_\_\_\_\_% Shoulder \_\_\_\_\_% Elbow \_\_\_\_\_% Wrist \_\_\_\_\_% Hip \_\_\_\_\_% Knee \_\_\_\_\_% Ankle \_\_\_\_\_%

ORTHOPAEDIC SPORTS MEDICINE \_\_\_\_\_%

NUMBER OF OFFICE/OUTPATIENTS REVIEWED: \_\_\_\_\_

SPECIALIZED CLINIC \_\_\_YES \_\_\_NO

\_\_\_\_\_ % Elbow \_\_\_\_\_ % Wrist \_\_\_\_\_ % Hip \_\_\_\_\_ % Knee \_\_\_\_\_ % Ankle

SPECIALIZED COURSES \_\_\_YES \_\_\_NO

\_\_\_\_\_ % Elbow \_\_\_\_\_ % Wrist \_\_\_\_\_ % Hip \_\_\_\_\_ % Knee \_\_\_\_\_ % Ankle

SCIENTIFIC ACTIVITY: PUBLICATIONS \_\_\_\_\_ MEETINGS \_\_\_\_\_ RESEARCH \_\_\_\_\_

NUMBER OF OPERATIVE PROCEDURES: OBSERVED \_\_\_\_\_ ASSISTED \_\_\_\_\_

## Additional Comments:

WOULD YOU RECOMMEND THIS CENTER? \_\_\_YES \_\_\_NO

Please provide an explanation for your answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why did you chose this particular center for your educational experience: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were your expectations met? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Kind of training: \_\_\_\_\_ Observing \_\_\_\_\_ Hands-on \_\_\_\_\_ Research

Were any of the following provided for you:

Lodging: \_\_\_\_\_ Provided by ISAKOS Teaching Center \_\_\_\_\_ Not provided by ISAKOS Teaching Center

Food: \_\_\_\_\_ Provided by ISAKOS Teaching Center \_\_\_\_\_ Not provided by ISAKOS Teaching Center

Salary: \_\_\_\_\_ Provided by ISAKOS Teaching Center \_\_\_\_\_ Not provided by ISAKOS Teaching Center

Primary Language: \_\_\_\_\_ English \_\_\_\_\_ Other: \_\_\_\_\_

SUGGESTIONS FOR IMPROVEMENTS OF THE TRAINING CENTER AND ITS PROGRAM:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_