# Participant Evaluation of ISAKOS Teaching Center

*Please complete this evaluation form and return it to the ISAKOS Office at 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:
_____
_____
_____
_____
_____
_____

*THIS INFORMATION WILL BE KEPT CONFIDENTIAL*