# New York State Tobacco Cessation Center
# Collaborative Statewide Conference Call Evaluation

**March 5, 2014**

**12:00 Noon – 1:00 PM**

**Treating Pregnant Women's Tobacco Use and Dependence**

Instructions: To obtain continuing education credit or a certificate of attendance, complete this Evaluation and Continuing Education Credit Claim form.

**Submit both forms by FAX to North Country Tobacco Cessation Center, Attn: Glenn Pareira, III at 518-891-6159 within seven days of the call.**

Respondent's information will be held confidential.

Certificates will be mailed within 6-8 weeks of the call date.

**Program objective(s): Upon completion of this program:**

1. Describe two evidence-based interventions to help pregnant smokers quit.
2. Assess an organization's guidelines to treat pregnant women's tobacco use with evidence-based treatment recommendations.
3. Discuss at least one gain and one challenge when treating pregnant women's tobacco users during the course of their pregnancy and postpartum.

**Please rate the following using a scale of 1 to 4, with 1 representing poor and 4 representing excellent**

| | |
|---|---|
| 1. Content of the presentation: | |
| 2. Program accomplished the stated objectives: | |
| 3. Teaching methods and aids were appropriate and used effectively: | |
| 4. Overall quality of the program: | |
| 5. The program provided me with new information and knowledge that may be pertinent to your practice and patient care: | |
| 6. The teaching effectiveness of the presenter: Rachel Boykan, MD, FAAP | |
| 6a. The teaching effectiveness of the presenter: Todd R. Griffin, MD | |

7. What percentage of information was new to you? Please circle:
   0-20%  21-40%  41-60%  61-80%  81-100%

8. As a result of attending this presentation: _____

9. Continuing education presentations must be "free of commercial bias for or against" any product.
Was this program fair, balanced, and free of commercial bias? Yes ___ No ___
If no, describe bias: _____

10. The provider of the activity has disclosed in writing or verbally the conflict of interest, or lack thereof, declared by the planners and presenters/content specialists. Yes ___ No ___

11. Suggestions for future topics/improvements: _____

12. Name: _____ **(mandatory for course credit)**

APFME Office of Continuing Medical Education
School of Medicine & Biomedical Sciences
University at Buffalo

# CME/COURSE CREDIT CLAIM FORM

***Please print legibly***

**TITLE:** *"Treating Pregnant Women's Tobacco Use and Dependence"*

**Date:** March 5, 2014

**CME Course #:** 008

XXX- XX- ☐☐☐☐ (Last four digits of Social Security Number or other CME ID number (registered with UB CME Office)

**Please circle one**: MD, DO, RPA-C, NP, CASAC, RT, LPN, RN, MSW/LSW, Mental Health Professional,
Other (please describe): _____

_____
Last Name First Name

_____
Street Address: *(where you wish certificate to be mailed to)*

_____
City State Zip Code

_____
Email

**Please indicate the number of hours you attended EACH session, enter the TOTAL in the box (lower right) and submit this form before you leave.**

| Scheduled Hours | Maximum Credit Hours | Actual Hours of Attendance |
|---|---|---|
| 12;00 pm – 1:00 PM | 1.0 | |

| | |
|---|---|
| Each physician/practitioner should claim only the actual time spent in each session 1.0 hours total for this program. (signature required) | TOTAL TIME SPENT |

**Please check ONLY one:**

_____ CME credit
_____ OASAS Education and training clock hours
_____ Certificate of completion
_____ CRCE: Please provide AARC membership number: #_____

Please return this completed form and evaluation (**by March 12, 2014**) to receive credit for this program. **FAX to Glenn Pareira, III at 518-891-6159.** Respondents information will be held confidential, to be forwarded only to the accrediting agency for CME/Continuing Education Credit. Thank you.