

**Health Systems for a Tobacco Free  
New York Statewide Collaborative Conference Call**

**June 3<sup>rd</sup>, 2015  
12:00 Noon – 1:00 PM  
Healthcare Systems Change to Identify and Treat Patients Who Use Tobacco**

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

**Submit both forms by FAX to Central NY Regional Center for Tobacco Health Systems,  
Attn: Beth Gero, Ph.D., CTTS at (315) 458-5715  
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:**

Please rate the following: use 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: Rob Adsit, MEd Director of Education and Outreach	

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)**

Office of Alcoholism and Substance Abuse Services  
Division of Quality Assurance and Performance Improvement  
Bureau of Workforce Development and Fiscal Evaluation  
**CASAC, CPP, CPS/COURSE CREDIT CLAIM FORM**  
*Please print legibly*

**TITLE: Healthcare Systems Change to Identify and Treat Patients Who Use Tobacco**  
**DATE: June 3, 2015**  
**Course: 0886**

Xxx-xx-\_\_\_\_ (Last four digits of Social Security Number or CASAC, CPP, or CPS ID number (registered with OASAS))

**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. <b>(Signature required)</b>	TOTAL TIME SPENT
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Please check ONLY one:

\_\_\_\_\_ OASAS (CASAC) Education and training clock hours

\_\_\_\_\_ Certificate of completion

Please return this completed form and evaluation (**by June 10, 2015**) to receive credit for this program.

**FAX to Beth Gero, Ph.D., CTTS at (315) 458-5715.** Respondents information will be held confidential, to be forwarded only to the accrediting agency for CASAC, CPP, CPS/Continuing Education Credit. Thank you.