

1. Are you a NEFS Member? Yes No*If no, are you interested in becoming an NEFS member?* Yes No
If no, why not? _____
2. How does this meeting compare to other NEFS meetings you have attended? Better Same Worse
Please explain: _____
3. How does this meeting compare to other educational meetings you've attended? Better Same Worse
Please explain: _____
4. Would you recommend this program to a colleague? Yes No
If no, why not? _____
5. How did you first learn of this program? Email Website Colleague Other _____
6. Before attending, please check all reasons why you decided to attend this program?

<input type="checkbox"/> Quality of speakers	<input type="checkbox"/> Needed credits	<input type="checkbox"/> Location
<input type="checkbox"/> Chance to interact with colleagues	<input type="checkbox"/> Chance to interact with speakers	<input type="checkbox"/> Topics
<input type="checkbox"/> Apparent value for expense	<input type="checkbox"/> Previous experience with NEFS Meetings	
7. Please indicate your primary profession:

<input type="checkbox"/> Physician	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Legal
<input type="checkbox"/> Physician's Assistant	<input type="checkbox"/> LPN/LVN	<input type="checkbox"/> Psychologist/Social Worker
<input type="checkbox"/> Pharmacist	<input type="checkbox"/> RN	<input type="checkbox"/> Embryologist
<input type="checkbox"/> Administrative (non-clinician)	<input type="checkbox"/> Other: _____	
8. Please recommend venue locations for future meetings. _____

9. Please recommend speakers/topics you'd like to hear at future meetings. _____

10. What were the strengths of this activity? (Please provide specifics:) _____

11. Suggestions to improve this program? _____

12. Based on the overall activity, were there any changes in your competence or performance or patient outcomes strategic?
 Yes No Please provide specifics: _____

13. Would you attend a purely networking event to connect with colleagues? _____
 Yes No Please provide ideas: _____

We welcome any additional feedback, recommendations, suggestions, and any additional comments: _____

CREDIT APPLICATION / CONTACT INFORMATION

Instructions: Applications for Credit will be accepted until **October 20, 2024.**

Please print clearly as illegible applications will result in a delay.

Name: _____ Title: _____

License #: _____ State of License: _____

Affiliation: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email (required): _____

Please indicate which credit you are requesting by checking the appropriate box below.

Physicians *Not available* Nurses *(sign in at registration)* Laboratory (ABB) *-(Not available for this activity)*

I certify that I participated in: The 3rd Quarterly Meeting/Fall Joint Meeting with Boston OBGYN Society
Total Number of Hours = up to 1.5hrs.

Signature: _____

Please Submit Completed Application to: *Send via mail or scan and email by October 20th to:*

**New England Fertility Society
c/o Michelle Picher
110 Patricia Drive,
Tewksbury, MA 01876**

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michellepicher@nefs.org