



FACE YOUR *Health*

LEARNING SESSION EVALUATION FORM

How did we do? Tell us what you think!

Today's Date: _____

About the Session

1. Was it helpful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Did you understand the information?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Did you learn something new?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. After the session, did you decide to get screened for cervical cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

About Your Community Health Worker

5. Was she a good teacher?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Did she know the material?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Did she listen to what you had to say?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> I didn't share anything

About Your Overall Experience

8. Would you recommend this session to a friend?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. How did you hear about this session?	Answer:	

