Cooper/Clayton Program Evaluation Form

Facilitator(s): ____

Program Dates: ______________________through___________________________

Program Location: ____

In an effort to continue to improve our smoking cessation program, please circle the following responses that best fit your feelings:

Please answer the questions below, using the following scale:
1 = very dissatisfied 2=dissatisfied 3=satisfied 4=very satisfied

How satisfied were you with...

		very dissatisfied	dissatisfied	satisfied	very satisfied
1.	overall comfort level of the room?	1	2	3	4
	comments:				
2.	length of each class?	1	2	3	4
	comments:				
3.	day of the week class held?	1	2	3	4
	comments:				
4.	time of day class held?	1	2	3	4
	comments:				
5.	your facilitators?	1	2	3	4
	comments:				

6.	time allowed for open discussion?	1	2	3	4
	comments:				
7.	overall program?	1	2	3	4
	comments:				

8. After 6 months of being a non-smoker, would you be interested in being trained to be a Cooper Clayton Method to Stop Smoking Facilitator? If yes, could we have your name and phone number?

9. Additional comments/suggestions:

Thank you for your time. We greatly appreciate your responses and comments.