

## NURSE AIDE TRAINING PROGRAM EVALUATION

Please complete this evaluation after you have completed the Nurse Aide Training Program:

**Return to: ALLIANT GEORGIA MEDICAL CARE FOUNDATION  
NURSE AIDE TRAINING PROGRAM  
P. O. Box 105753  
Atlanta, Georgia 30348  
FAX: 678-527-3034 or 877-399-8273**

Name of Nurse Aide Training School/Facility: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Student's E-mail Address: \_\_\_\_\_

Student's Phone Number (Optional): \_\_\_\_\_

- How many hours per day did you attend class - did you feel that the amount of hours were adequate for your learning needs? Hours: \_\_\_\_\_ YES ☐ or NO ☐
- What time did the classroom hours begin and end? Begin \_\_\_\_\_ End \_\_\_\_\_
- How many hours did you attend clinical? Hours: \_\_\_\_\_
- Did the instructor portray a professional mannerism? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Was the instructor knowledgeable on nurse aide training? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Was the instructor on time for classes and clinical rotation? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- What was the name of your primary nurse aide training instructor?  
\_\_\_\_\_
- Did you have the same instructor throughout the class? If not list each instructor. If not a RN/LPN, what was the instructor's title? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Are you comfortable taking care of residents of a long-term care facility based on the classroom/lab and clinical training you received? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Was time allotted for the skills to be checked off with 100% accuracy in the lab portion of your training prior to clinical rotation? YES ☐ or NO ☐  
Comments \_\_\_\_\_

- Was the clinical rotation long enough for you to feel comfortable in caring for residents of a long-term care facility? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Was the instructor with you at all times during your clinical rotation? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Was there time allowed for questions to be answered? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Do you feel you received a quality education? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Would you recommend this Nurse Aide Training Program to a friend? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Did you perform vital signs (temperature, pulse, respiration and blood pressure) in the classroom and during clinical rotation? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- Do you feel confident performing vital signs accurately? YES ☐ or NO ☐  
Comments \_\_\_\_\_
- If necessary, can your identity be revealed to the program? YES ☐ or NO ☐  
Comments \_\_\_\_\_

Additional Comments are welcomed: \_\_\_\_\_  
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Please use another sheet of paper if additional space is needed.