NURSE AIDE TRAINING PROGRAM EVALUATION

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

Return to: **ALLIANT HEALTH SOLUTIONS**
NURSE AIDE TRAINING PROGRAM
P. O. Box 105753
Atlanta, Georgia 30348

Name of Nurse Aide Training School/Facility: _____
Student's Name: _____
Student's E-mail Address: _____
Student's Phone Number: _____

- 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.