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.

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