



**2011 Annual Managed Care Conference
Survey and CLE/CME Applicant Information**

RESPONDENT NAME (OPTIONAL) _____

ORGANIZATION _____

LICENSES NUMBER _____

CLE OR CME (PLEASE SPECIFY AND INCLUDE PROFESSION – ATTORNEY, NURSE, MD, ETC.)

SEND MY CERTIFICATE TO: (SPECIFY EMAIL ADDRESS: _____)

OVERALL CONFERENCE

**Please rate your overall satisfaction with this conference.
SCALE 5 = terrific and 1= terrible**

- | | | | |
|---|-------|-----------|-------|
| 1. Venue – facility, service, food, cost, | _____ | COMMENTS: | _____ |
| 2. Location | _____ | COMMENTS: | _____ |
| 3. Registration process | _____ | COMMENTS: | _____ |
| 4. Networking opportunities | _____ | COMMENTS: | _____ |
| 5. Value for cost: | _____ | COMMENTS: | _____ |
| 6. Speakers: | _____ | COMMENTS: | _____ |

COMMENTS:

Thank you for your feedback and continued support.
Please Email to pdoner@tahp.org or Fax: (512) 476-2870