Post Evaluation Reporting Form:

Name & Credentials: ____________________________________________

1. What type of organization are you employed at?
   a. Trauma center
   b. Hospital/hospital system
   c. Fire department
   d. Police department
   e. Child care/day care center
   f. School system
   g. Child advocacy center
   h. Other (please specify): ______________________________________

Date Training was completed: ______________________________________

Number of inspections performed at clinic: ___________________________

Did you have an increase in knowledge regarding car seat safety? 
   YES  NO

Are you bilingual? YES  NO

If so, what languages are you fluent in? ______________________________

What counties will your organization be working with regarding child passenger safety?
   __________________________________________________________________
   __________________________________________________________________

Is there any additional information (resources, data, training, etc.) that you might find beneficial for another class?
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________