



LUCAS[®] 2 CHEST COMPRESSION SYSTEM

Training - Evaluation & Feedback

Date: _____

Name (optional): _____

Title: _____

Please circle the number that best represents your opinion on numbers 1-5 and complete the statements with your opinion on questions 6 and 7. When you have completed this evaluation, please place it in the designated envelope or give it to your trainer.

LUCAS 2 Chest Compression System	Disagree Strongly					Agree Strongly				
1. The instructor was prepared.	1	2	3	4	5					
2. The instructor was knowledgeable about the session content.	1	2	3	4	5					
3. The instructor was able to retain my attention throughout the training.	1	2	3	4	5					
4. The material I learned in this session will help me be more effective in applying and operating the LUCAS device.	1	2	3	4	5					
5. The hands-on session helped me feel comfortable handling and deploying the LUCAS device.	1	2	3	4	5					
6. The best thing about this session was: _____										
7. If I could change one thing about this session, I would: _____										
8. Additional comments/feedback: _____										