TRAINING SOLUTIONS
Individual Care. Integrative Solutions.

Training Solutions Classes/Programs/ Instructor Feedback Form

Name _____
Address _____
Email _____
Phone _____

Name of Class/Program _____
Date _____

Is Training Solutions/or the off site class/program easy to get to and conveniently located?
❑ Yes ❑ No

Were the class/program hours convenient?
❑ Yes ❑ No

Where your expectations of the class/program met?
❑ Yes ❑ No

Were you comfortable throughout the class/program?
❑ Yes ❑ No

Was the content/quality of the class/program what you were looking for?
❑ Yes ❑ No

How would you rate the overall class/program 1-5 scale? (1 = Excellent 5 = poor)
1 2 3 4 5

Please rate each instructor:

Name of Instructor _____

Did the Instructor met your expectations for the class/program?
❑ Yes ❑ No
Other Comments: _____

Did you have fun at the class?
❑ Yes ❑ No
Other Comments: _____

Did you learn from the Instructor?
❑ Yes ❑ No
Other Comments: _____

What other instructors would you like to have instruct? _____

What class/program would you like them to instruct? _____

What suggestions for other topics/areas of interest would you have provided by/at Training Solutions?
_____

Would you refer this class/program to others?
❑ Yes ❑ No

Would you refer Training Solutions to others?
❑ Yes ❑ No

Other suggestions or comments? _____
_____
_____
_____
_____
_____