

## PARTICIPATION EVALUATION FORM

NAET Advanced 2 P

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**Provider's Name and Number**

Dr. Devi S. Nambudripad, AC 089

**Course Beginning date:** 11/20/2018 7:35:36 AM

**Course Ending date:** 7/30/2023 8:27:47 PM

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**Participant's name and License #:**

Allison Blakewell  
TX, RN

**Date of Evaluation:** 7/30/2023

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**Did this course meet its STANDARD OBJECTIVES?**

yes

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**Did the Instructor Demonstrate adequate knowledge about the course subject?**

yes

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**Did the instructor utilize appropriate teaching methods**

yes

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**Do you feel that you will be able to apply what you have learned from this course to your practice?**

yes

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**Would you recommend this course to other licensed medical professionals?**

yes

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**Do we have your permission to share your views with other practitioners?**

yes

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