Office of Health Services

EVALUATION OF HEALTH SERVICES

Please take a few minutes to complete this questionnaire. The information provided will assist us in improving our services to you.

Person completing this form: Student _____ Administrator _____ Visitor _____
Faculty _____ Staff _____ Other ____________

Indicate the type of service: (Please check all that applies)

_____ Emergency First Aid
_____ Immunization Clearance
_____ Health Clinic
_____ On Campus Parking
_____ Special Program Health Review
_____ Health Stop or WA Grade
_____ Medical or Psychological Consultation
_____ Incident Report or Compensation Form Follow-up
_____ Employee Returning to Duty/Medical Documentation
_____ Medical Withdrawal or Class Withdrawal
_____ Other ______________________________________________________________________

I was seen by the following person(s):

Staff _____ Nurse _____ Doctor _____ Director _____

Please rate the quality of the service to you: Excellent Good Average Poor

Seen in a timely manner         ____   ____       ____       ____
Courteous and attentive to my problem    ____   ____       ____       ____
Knowledgeable and supportive        ____   ____       ____       ____
Made appropriate referral           ____   ____       ____       ____

Please place below additional comments and/or suggestions for improvement:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

THANK YOU