ACCESSIBLE CUSTOMER SERVICE FEEDBACK FORM

Thank you for visiting the Carleton Place & District Memorial Hospital. We value all of our clients and strive to meet everyone’s needs.

Please tell us the date and time of your visit: ______________ at _______.

Staff Person or Position: ___________________________

Location: ___________________________ Department: ___________________________

Did we respond to your customer service needs today?
☐ YES ☐ SOMETHAT (please explain below) ☐ NO (please explain below)

___________________________________________

___________________________________________

Was our customer service provided to you in an accessible manner?
☐ YES ☐ SOMETHAT (please explain below) ☐ NO (please explain below)

___________________________________________

___________________________________________

Did you have any problems accessing our goods and services?
☐ NO ☐ YES (please explain below) ☐ SOMETHAT (please explain below)

___________________________________________

___________________________________________

Please add any other comments you may have:

___________________________________________

☐ Please check the box if you would like to receive a response to your feedback.

Contact information: ___________________________