SONSHINE MEDICAL, INC.

Customer/Client/Referral Satisfaction Survey

Date: ____________________

Name (Not Required): ____________________ Facility Name: __________________________

REGARDING SONSHINE MEDICAL INC:	**Extremely Satisfied**	**Satisfied**	**Dissatisfied**	**Extremely Dissatisfied**
Was the equipment/service provided in a timely manner?				
Were all your questions answered to your satisfaction?				
Were you satisfied with the quality of the equipment/service?				
Were you satisfied with the variety of equipment we offer?				
REGARDING THE STAFF:				
Were the staff members courteous and professional?				
Were the staff members knowledgeable on the equipment delivered/installed?				
How would you rate the staff member's response time to meeting your needs?				

1. Were all procedures/services explained prior to performing them?

   ❑ Yes ❑ No

2. Were you given complete instructions on your equipment/care?

   ❑ Yes ❑ No

3. Were you instructed on who/where to call with questions or problems?

   ❑ Yes ❑ No

4. Would you recommend our equipment/services to others?

   ❑ Yes ❑ No

Please share your comments or suggestions on how we might serve you better:

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