**MEDICAL EQUIPMENT CUSTOMER SERVICE EVALUATION**

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| **Please complete the following evaluation to assist in evaluating the**  **(Name of MTF’s) Medical Equipment Management Program**  ***5 = very satisfied 4 = satisfied 3 = fairly satisfied 2 = poor 1 = very poor***  **1 2 3 4 5 Ease of contacting the Medical Maintenance Branch**  **1 2 3 4 5 Prompt response to service requests**  **1 2 3 4 5 Timely completion of equipment maintenance**  **1 2 3 4 5 Effective communication on the status of equipment requiring service**  **1 2 3 4 5 Technical competence of medical equipment repairers**  **1 2 3 4 5 In-service training provided on equipment user maintenance requirements**  **1 2 3 4 5 Support received from Chief, Medical Maintenance Branch**  **1 2 3 4 5 Assistance with selection of new or replacement equipment items**  **1 2 3 4 5 Professionalism of the staff**  **1 2 3 4 5 The overall effectiveness of the Medical Equipment Program in meeting your needs**  **Other Comments:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Department:**  **Date:**  **Name(s) of medical equipment repairer:** |
| ***THANK YOU!***  **Please drop off at the customer service drop off at the Logistics Department.** |