|  |  |
| --- | --- |
| **Date** |       |
| **Name** |       |
| **Company**  |       |
| **Workplace Rehabilitation Consultant name** |       |

We would be most appreciative if you can take the time to complete and return this survey to Embrace Workplace Consulting.

Your feedback is important to us and will assist us with reviewing our services.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Question** | **Poor** | **Satisfactory** | **Excellent** | **Comment** |
| 1. Time of response to referrals
 |       |       |       |       |
| 1. Quality of service and assessments provided
 |       |       |       |       |
| 1. Quality and timeliness of reports
 |       |       |       |       |
| 1. Level of Communication
 |       |       |       |       |
| 1. Formulation / coordination / management of rehabilitation programs (if applicable):
 |       |       |       |       |

Specific Comments: Are there any aspects of our service that you consider needs improvement?

|  |  |  |
| --- | --- | --- |
|       |  |       |
| **Name** |  | **Date** |

Thank you for taking your time to complete this survey and assisting in our quality assurance program.

Embrace Workplace Solutions