CUSTOMER FEEDBACK FORM

As a valued customer we would appreciate a small amount of your time to complete the following Customer Feedback Form, our representative will complete this with you and return on your behalf.

The feedback information will be used to assess company performance, and to ensure product quality, customer satisfaction and service is achieved to the highest possible level to sustain your commitment.

Completed by:			
Hospital Name:			
Name:		**Department:**	
Signature:		**Date:**	

Please provide a rating for your experience by ticking in the corresponding boxes.	***Excellent***	***Good***	***Fair***	***Requires Improvement****
Customer Service Experience *(courtesy of staff, ease of contact)*				
Customer Service Response Time				
Customer Support *(product/information requests/technical support)*				
Delivery Service *(delivery time, communication of any delays)*				
Loan Service *(delivery time, presentation, communication)*				
Loan Kit Quality Documents				
Competitiveness				
Product Quality				
Product Pricing				
Ease of obtaining required information through the company website - *(www.orthosol.com)*				
Meeting your requirements overall				
What makes you choose Ortho Solutions products?	☐ N/A			
**** How can we improve areas which you feel require improvement?***				

Internal review by Customer Services / RA Department:

Name	***Title***	***Signature***	***Date***