Exhibit A

RIVER VALLEY
FAMILY HEALTH CENTER

Feedback Form

Our goal is to provide excellent quality of care and first-class customer service. This form may be used to provide any comments or concerns about the services or experience you received.

Today's date: _____

Reported Before: ◯ No ◯ Yes

Comments/Concerns and your ideas for how we can fix it, if you have any:

_____
_____
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_____

Date this happened: _____

Completed By (if staff member):_____

Patient Name:_____

May River Valley Family Health Center contact you regarding the comments made in this form? YES NO
What is the best number to contact you at:_____

For Clinic Use Only

Summary of Investigation:_____
_____
_____
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_____
_____
_____

Completed By:_____ Date:_____

Plan of Resolution:_____
_____
_____
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_____
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_____

Completed By:_____ Date:_____

Follow-Up with Concerned Party, if deemed necessary (Person who initiated form):_____
_____
_____
_____
_____
_____
_____

Completed By:_____ Date:_____

Date taken to QA/QI Meeting for discussion: _____