State of California—Health and Human Services Agency

California Department of Public Health

Dear Provider:

This evaluation is provided as a means for your facility to share information concerning its recent General Acute Care Hospital Relicensing Survey and as a way to assist us in improving the survey process. Please use the scale below to rate us in each of the areas identified. If you select a 2 or 3 rating, please address these with specific explanatory comments below, or by attachment.

Please understand that completing this evaluation is strictly voluntary and is not required. Once you have completed it, please either **FAX it to (916) 324-4820** ***OR*** **mail it to the Licensing & Certification Program; Field Operations Support Unit, 1615 Capitol Ave., MS 0512, Sacramento, CA 95899-7413 ATTN: Susan Kent.** Thank you.

Type of Survey: (circle one) 3 year visit Periodic licensing Other _____

Name of Facility (optional):_____

5 Excellent	4 Good	3 Fair	2 Poor	1 Not Applicable

1. Survey staff introduced themselves and explained the survey process when the survey began. 5 4 3 2 1
2. Facility staff was informed during the course of the survey of information needed to complete the survey 5 4 3 2 1
3. Sufficient explanation and assistance was given to complete the necessary forms..... 5 4 3 2 1
4. Areas of concern were presented in a clear and concise manner. 5 4 3 2 1
5. During the exit conference, investigative findings were discussed adequately and/or there was an opportunity to provide the Department with additional information related to a violation. 5 4 3 2 1
6. Questions in regard to the regulations, licensure, or certification were addressed..... 5 4 3 2 1
7. The survey was conducted in a professional manner. 5 4 3 2 1

Please include comments (please feel free to attach additional pages as necessary).

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