



State of California—Health and Human Services Agency
California Department of Public Health



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Interim Director

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Center for Health Care Quality, Licensing and Certification Program

Dear Provider:

This evaluation is provided as a means for you to share information concerning the survey process and a way to assist us in improving it. 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 Branch, 1615 Capitol Ave., 73-460, MS 3001, P.O. Box 997377, Sacramento, CA 95899-7377 ATTN: Field Operations Branch Chief assigned to General Acute Care Hospitals. Thank you.

Type of Survey: Patient Safety Licensing Survey

Name of Facility: _____

Table with 5 columns: 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 Statutes and/or Regulations were addressed. 5 4 3 2 1
7. The survey was conducted in a professional manner. 5 4 3 2 1

Please include comments. You may continue the comments on the back or attach additional sheets.

Four horizontal lines for providing comments.