

Accessibility Service Feedback Form

We strive to meet your accessibility needs! Please help us to improve our services by giving us your feedback!

Please tell us the date and location of your visit:

Date: _____ Location: _____

1. Were you happy with the help you received from us?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Somewhat
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Comments

2. Did you find our office to be welcoming and easy to access?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Somewhat
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Comments

3. Were you comfortable at all times during your visit?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Somewhat
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Comments

4. Please tell us about your communication needs so that we can serve you better.

Contact Information (optional)

Name: _____ Phone Number: _____

Email: _____

Thank you,
Quality Assurance