Client Satisfaction Survey:

Name: ___________________________ Date: __________________

1. Was the vision screening location convenient for you? YES ______ NO ______

2. Did you receive a satisfactory vision screening? YES ______ NO ______

3. Was your screener helpful with vision resources? YES ______ NO ______

4. Did you link with an optometrist afterwards, and do you have your glasses? YES ______ NO ______

5. If you were pleased with your assistance from PVF, would you consider telling us about your experience and/or provide a photo? Please feel free to share on the lines below:

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Feedback/How Could We Improve?:

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