



Ohio AFIX Provider Satisfaction Survey

In an effort to continually improve our quality assurance program, we ask that you please take a moment to fill out this survey regarding the AFIX Feedback Session that you attended. Your answers will help to improve the program, our service to you, and the health of Ohio's children.

Provider/Clinic Name: _____ County: _____

VFC # : _____ Date of Feedback Session: _____

Please circle the answer that corresponds with your opinion:

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
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	5	4	3	2	1
1. The goals and objectives of the AFIX session were clearly communicated.	5	4	3	2	1
2. The time allotted for the session was sufficient considering the information that was discussed.	5	4	3	2	1
3. The AFIX representative was knowledgeable regarding the methods of the assessment and the results.	5	4	3	2	1
4. It is clear what activities our staff will be implementing to improve our immunization delivery.	5	4	3	2	1
5. The AFIX representative was helpful in coming up with actions for the improvement plan.	5	4	3	2	1
6. Our immunization rates were what we thought they would be.	5	4	3	2	1
7. Having an AFIX helps us to better understand the immunization rates of our pediatric population.	5	4	3	2	1
8. I would recommend the AFIX continuous quality improvement process to a colleague.	Yes		No		

Additional Comments:

Please return completed survey via fax:

Attn: Alex Thornton

Fax: (614)728-4279

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Office Use Only
Initials: _____