



QUALITY OF SERVICES SURVEY

Private

Name: (Optional)
Date:
Vehicle Number/Attendants Names:

For each item identified below, please circle the number to the right that best indicates your impression of RNR's quality of service. Utilize the scale (1-5) to select the appropriate number.

Description/Identification of Survey Item	Scale				
	Poor-----Excellent				
1. Rate the level of customer service you received from dispatch	1	2	3	4	5
2. Rate the ability of dispatch to accurately explain our service and pricing information.	1	2	3	4	5
3. Did the RNR Team arrive on time?	NO		YES		
4. Was the RNR Team courteous, friendly and helpful to the patient and hospital staff?	1	2	3	4	5
5. Was the team compassionate to the patient and their needs while transferring from the bed to the stretcher?	1	2	3	4	5
6. Were the RNR attendants offering assistance to you while enroute and/or at the receiving facility?	1	2	3	4	5
7. When waiting at a receiving facility, did at least one attendant remain with you to assist with patient care?	1	2	3	4	5
8. Rate the quality of driving exhibited by RNR attendants.	1	2	3	4	5
9. Rate the appearance of the vehicles' interior	1	2	3	4	5
10. Rate the appearance of the vehicles' exterior	1	2	3	4	5
11. Rate the professionalism of the service offered to you by the attendants.	1	2	3	4	5
12. Rate your impression of the patients's experience with RNR.	1	2	3	4	5
13. Rate your trip overall.	1	2	3	4	5
14. Rate the extent to which you would recommend RNR to others.	1	2	3	4	5

RNR is pleased to accept any suggestions to better improve our service. As well as, any positive comments RNR management could pass on to attendant(s), or the team as a whole.

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Thank you for allowing the RNR team to serve your transfer needs.  
Feedback is appreciated & valued.

**“RNR, Your Help on the Road to Recovery”**