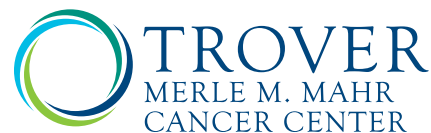


Please take a minute to tell us how we're doing.
Our goal is excellent care, every time!



		Excellent	Very Good	Good	Fair	Poor
1.	Check In Process					
2.	Registration Process					
3.	Nursing Care					
4.	Doctor _____					
5.	Treatment: <input type="checkbox"/> Chemo/Infusion					
	<input type="checkbox"/> Radiation					
6.	What can we do better?					

Name (optional): _____

Date of visit: _____