

Sample VFC Provider Feedback Survey

We'd love to hear what you think about the Vaccines for Children program. Please take a minute to complete the following survey. Your answers will help us improve the program to serve both you and our children better.

Provider/Clinic Name: _____ **Type of Practice:** Private Solo Practice Private Group Practice
 Federally Qualified Health Center/Rural Health Center
 Health Department Clinic Other: _____

Practice Specialty Type Pediatrics Family practice Internal Medicine Multispecialty Health Department Clinic Other: _____

Address: _____
Street City County Zip Code

Telephone Number: _____ **E-Mail:** _____

Person Completing the Survey: _____ **Title:** _____

***WE WANT TO KNOW WHAT YOU THINK ABOUT THE VFC PROGRAM.
PLEASE RATE YOUR EXPERIENCE FOR QUESTIONS 1 - 9 USING THE SCALE FROM 1 TO 5.***

		Very Satisfied				Very Dissatisfied	
1. The support, information and materials provided by state/local VFC program staff.	1	2	3	4	5	NA	
2. The ease of screening patients for VFC-eligibility.	1	2	3	4	5	NA	
3. The ease of VFC record keeping.	1	2	3	4	5	NA	
4. The ease of using the VFC vaccine ordering system.	1	2	3	4	5	NA	
5. The timeliness of VFC supplied vaccine delivery.	1	2	3	4	5	NA	
6. The condition of VFC supplied vaccine at delivery.	1	2	3	4	5	NA	
	Very Satisfied				Very Dissatisfied		

7. The decreased need to refer children to public clinics for immunizations. 1 2 3 4 5 NA
8. The merit of the VFC vaccine accountability system (reporting the number of doses administered, benchmarking, etc.) 1 2 3 4 5 NA
9. Overall satisfaction with the VFC program 1 2 3 4 5 NA
10. The range of vaccine brand choice available for VFC vaccines 1 2 3 4 5 NA
11. Which vaccines are routinely recommended in this practice/clinic? (Please check all that apply)
- | | |
|--|---------------------------------------|
| <input type="checkbox"/> DTaP | <input type="checkbox"/> MMR |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pneumococcal |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Hib | <input type="checkbox"/> Varicella |
| <input type="checkbox"/> HPV | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Meningococcal | <input type="checkbox"/> Rotavirus |
| <input type="checkbox"/> Others: _____ | |
- 12a. Does this practice/clinic have a systematic way to identify and recall children in need of vaccinations? Yes No
- 12b. If yes, what kinds of system do you use? recall system, computerized
 recall system, tickler file
 registry
 periodic chart reviews
 other: _____
- 13a. Have immunization coverage levels been assessed in your practice within the last year? Yes No
- 13b. If yes, by whom? Own practice/clinic staff State health department staff
 Local health department staff MCO staff
- 13c. If yes to 13a., what assessment tool was used? CoCASA Other: _____ Do not know
- 13d. If yes to 13a., what age & series was assessed? _____ Do not know
- 13e. If yes to 13a, what was the coverage level _____% Do not know
14. Does this practice/clinic participate in a state/local immunization registry? Yes No

15. What recommendations do you have for improving the VFC program? _____

Please fax or mail your completed form to:

Your Health Department's Name

Attn: VFC Program

Street Address

City, State, Zip

Telephone: () _____ Fax: () _____

This document can be found on the CDC website at:

<http://www.cdc.gov/vaccines/programs/vfc/downloads/vfc-op-guide/23-appx-7-prov-surv-sample.pdf>