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
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)

☐ DTaP ☐ MMR
☐ Hepatitis A ☐ Pneumococcal
☐ Hepatitis B ☐ Polio
☐ Hib ☐ Varicella
☐ HPV ☐ Influenza
☐ Meningococcal ☐ Rotavirus
☐ 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? _____

13e. If yes to 13a, what was the coverage level _____%

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 in (specify state)? _____

_____

_____

_____

_____

Please fax or mail your completed form to:

Your Health Department's Name
Attn: VFC Program
Street Address
City, State, Zip
Telephone: ( ) _____ Fax: ( ) _____