CONCERN: EAP DATE: _____

Please take a few moments to tell us how you feel about your experience with our services. Your response is completely confidential and greatly appreciated.

What is the name of your company/organization? _____

How would you rate your counselor's knowledge and competency?

❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor

How would you rate the usefulness of the service in helping you develop a plan to deal with your problems?

❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor

What is the likelihood that you would use our services again if you needed them?

❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor

What is the likelihood you would recommend our services to your co-workers or family members?

❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor

What is your overall rating of our services?

❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor

Circle the number that best describes the extent to which you feel your work performance has improved since using the EAP

5 4 3 2 1
Significant improvement No change

Circle the number that best describes the extent to which you have avoided missing days at work or arriving late to work since using the EAP

5 4 3 2 1
Significant improvement No change

Circle the number that best describes the extent to which you feel your overall health and sense of well-being has improved since using the EAP

5 4 3 2 1
Significant improvement No change

Circle the number that best describes how valuable it is to you to have an EAP as a part of your benefit package.

5 4 3 2 1
Extremely valuable Not valuable

What did you like best about our services?

Other comments?

Your counselors' name (optional): _____

If there is anything about our services that you would like to discuss,
Please contact a Clinical Manager at 800-344-4222 or 650-940-7100.
PLEASE FOLD AND SEAL BEFORE MAILING. THANKS FOR YOUR RESPONSE