## Provider Survey

OMB Control #: 0925-0655
Expiration Date: 04/30/2018

As a person who Provides the Medsaway® Medication Disposal System, your answers to the following questions would be greatly appreciated to evaluate the interest of Providers in this product and to collect information that may be useful for product improvements.

Completing this survey is completely voluntary, the survey is anonymous, no personal information is being collected, and participants are not identifiable through this survey.

Public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH Project Clearance Branch, 6705 Rockledge Drive, MSC 7974 Bethesda MD 20892-7974, ATTN PRA (0925-0655). Do not return the completed form to this address.

**1. When would you provide the product to client/customers/public?**

- ○ Provide with every interaction
- ○ Provide only if the person asks for it
- ○ Provide if the situation or interaction warrants it
- ○ Never

If never, or situation or interaction warrants it, please explain:

**2. Do you have any suggestions for product improvement?**

- ○ No
- ○ Yes

If "Yes", please specify improvements.

**3. Why did you provide this product? Please check the benefits you believe would apply for users:**

- ☐ to lower the risk of abuse or diversion
- ☐ to lower the risk of accidental poisoning
- ☐ to remove prescription drugs from homes without causing environmental damage

Other (please specify)

**4. Do you plan to continue to provide this product?**

- ○ Yes, I plan to continue providing this product
- ○ No, I don't plan to continue providing this product
- ○ If no, please specify your reasons:

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**5. Are you aware of any complaints or adverse events that persons have experienced when using the product?**

- ○ Yes
- ○ No

If yes, please specify:

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**Thank you for your time!**

Done