


Figure B – Updated Form

**VA** |  **U.S. Department of Veterans Affairs**

Dear Veteran or Veteran Advocate,

The VA would like to hear your compliments, recommendations, or concerns regarding your most recent visit to the Medical Facility.

Thank you for choosing VA!

Please click [here](#) to read the Respondent Burden.

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Please identify the most recent location where you received services provided by the VA

Select State

Select Primary Medical Center

Select Medical Facility *(\*Required)*

Select the expression that best describes your experience. *(\*Required)*

**Figure B – Updated Form (cont'd)**

Do you want to share a compliment, recommendation, or concern? *(\*Required)*

- Compliment
- Recommendation
- Concern

Tell us more about your experience. *(\*Required)*

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First Name *(\*Required)*

Last Name *(\*Required)*

Last 4 Digits of Social Security Number *(\*Required)*

Date of Birth (Format: MM/DD/YYYY) *(\*Required)*

Phone Number (Format: 999-999-9999) *(\*Required)*

E-mail Address