[State Letterhead]

{current_date}

[Addressee Information]

[SNO Language]

[Spanish Language]

We are the office that makes disability decisions for the Social Security Administration. As part of your/{clmt/bene_full_name}'s application for disability benefits, we scheduled an examination for you/him/her with a doctor in your area. We are committed to providing quality services to every claimant. We would like your feedback regarding the examination.

Instructions: Please complete this survey as soon as possible after your/his/her examination by {ce_provider_name} on {ce_exam_date}. Your response will not be associated with your/his/her claim and will not impact the decision about your/his/her disability benefits. Return the completed survey in the enclosed envelope by {clmt_form_return_date}.

If you have any questions, please contact us at the number(s) shown below {local_office_hours}. When you call or leave a message, please provide the Case ID: {case_id}, your name/your name, his/her name, and a call back number.

Thank you for your help.

Enclosure]
Return envelope
Consultative Examination Survey

[**Approved, OMB Number 0960-0788]**

CONSULTATIVE EXAMINATION SATISFACTION SURVEY

1) Did you understand the purpose of the exam? ☐ Yes ☐ No

If no, explain _____

_____

2) Did you have any problems finding the doctor's office? ☐ Yes ☐ No

If yes, explain _____

_____

3) Were the facilities neat, clean, and easily accessible? ☐ Yes ☐ No

If no, explain _____

_____

4) Were the doctor and office staff courteous and professional? ☐ Yes ☐ No

If no, explain _____

_____

5) How long did you have to wait before you saw the doctor? _____

6) How long were you with the doctor? _____

7) Please rate your overall experience (circle the number).

1	2	3	4	5
(Very Dissatisfied)		(Neutral)		(Very Satisfied)

Additional Comments:

_____

_____

_____

[**Approved, OMB Number 0960-0788]**

Paperwork Reduction Act Statement – This information collection meets the requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: *SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

[**Approved, OMB Number 0960-0788]**