



Dear George Foundation for Sight Restoration Patient,

We value your feedback and experience with the George Foundation for Sight Restoration. We would greatly appreciate if you would take a moment to answer the following questions. Once you complete the form, please place the form in the return envelope and mail it back to us or you may fax it to 972-570-1103. We look forward to your participation.

Sincerely,

George Foundation for Sight Restoration

1. How did you learn about the George Foundation for Sight Restoration? Please be as specific as possible.

- Community Clinic: _____
- Physician: _____
- Online: _____
- Friend or family member: _____
- Other: _____

2. How long have you been (or were) a George Foundation for Sight Restoration patient?

- Less than one year
- 3 years
- 1 year
- 4+ years
- 2 years
- Other _____

3. What benefits have you received from this program? (check all that apply)

- Eye surgery
- Eye surgery rental equipment
- Eye drops/medications
- Eye injections
- Eye laser procedures
- Eye Imaging/Diagnostics/Testing
- Routine eye exams
- Eyeglasses
- Special contact lens
- Eye prosthetic
- Other _____

4. On a scale of 1-10 (1 being "very difficult" and 10 being "very easy"): _____
How easy was it to apply and qualify for this program?

Please provide details:

5. On a scale of 1-10 (1 being "not satisfied" and 10 being "very pleased"): _____
Overall, how pleased are you with the George Foundation for Sight Restoration?

Please provide details:

6. Has your vision improved since receiving care through the George Foundation for Sight Restoration? Yes No

If no, please explain why you think this is.

(please continue on back side of page) →



7. If you are currently employed, skip to Question #9.
- Were you employed before your vision impairment? Yes No
 - If yes, are you able to *regain* employment after your medical eye care services?
Yes No If no, please explain why _____

8. Did your poor vision affect your employment in any capacity? Yes No

9. What impact (if any) has receiving George Foundation for Sight Restoration services had on your life?

10. Would you be willing to share your story with others? Yes No

(If so, please fill out the patient testimonial page. Your story helps spread awareness and promote our organization to be able to continue helping others.)

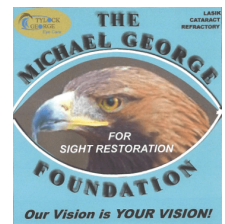
11. How can we make the George Foundation for Sight Restoration program better?

MEDIA RELEASE INCLUDING TESTIMONIAL

I, _____, hereby consent / do not consent (**please circle one**) George Foundation for Sight Restoration the right to use, publish and copyright my name, picture, testimonial and likeness in advertising, promoting, and publicizing George Foundation for Sight Restoration (product or service) in any manner or form throughout the world in perpetuity.

Printed Name _____ Date _____

Signature _____



You may fax this document to 972-570-1103, or mail back using the enclosed envelope.

Thank you for your feedback.

Patient Testimonial

*We would love to be able to share your story to help spread awareness about our organization and the patients we serve. Please feel free to enclose any post-care photos to show how you are doing after receiving care through the George Foundation for Sight Restoration. **Note: We will only use your first name when sharing your story.***

Please feel free to write/type your story on a separate page or use the space below:

