GEORGE FOUNDATION
FOR SIGHT RESTORATION

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: _____ ☐ Friend or family member: _____
☐ Physician: _____ ☐ Other: _____
☐ Online: _____

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

☐ Less than one year ☐ 1 year ☐ 2 years
☐ 3 years ☐ 4+ years ☐ Other_____

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

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

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 you 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: