WHAT IF...

FACILITY EVALUATION FORM

Facility Name		CCN	
Contact Name		Phone	

1. Total number of patient pledges for the campaign: ____________

2. Please rate your overall satisfaction with the *WHAT IF…KCER Awareness Campaign*

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

   If Fair or Poor, please provide additional comment:

3. Please describe the activities your facility used to engage patients in the campaign:

4. Please describe how these activities were received by patients:

5. Please list the top three challenges your facility identified while implementing the campaign:

6. Please list the top three successes/best practices your facility identified while implementing the campaign: