

Optional:

Would you like someone to follow up with you? **Y** **N**

If so, please provide your contact information in the following section.

Patient Name: _____

Date of Birth: _____

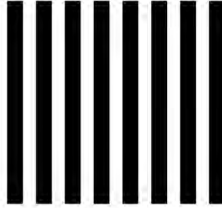
Mailing Address: _____

Phone #: () _____

Email Address: _____

Contact Preference: (circle one) Email Phone

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 12 SITKA AK

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ATTN: PERFORMANCE IMPROVEMENT DIVISION
SEARHC
222 TONGASS DR
SITKA AK 99835-9987



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SEARHC Customer Experience Feedback Form

Your feedback will help us provide the highest quality of care.



