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**QF 13**

**QUALITY UNIT**

CUSTOMER FEED BACK FORM

In line with our ***vision*** to be an effective medicines and medical devices regulator in Zimbabwe and leading regulatory authority in the world, we kindly request you to use this form to give us your feedback. It is important to us.

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| ***Please tick where applicable***  **1.This feedback is a  Suggestion  Compliment  Complaint** |

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| ***Please tick where applicable***  **2. About which office 3. About which issue**  Main Gate Reception Enquiries / Information  Main Reception Licensing of Premises/Persons  Director General’s Office Timeliness of service  Registration and Evaluations Staff actions /customer service  Pharmacovigilence and Clinical Trials Accessibility of service  Public Relations Fees/charges  Information and Communication Technology Website  Legal and Corporate AffairsImport/Export Licence  Administration Administration of legislation  Human ResourcesInspections/Investigations  Chemistry Laboratory Registration of medicines  Microbiology LaboratoryOther (*specify)………………………………….*  Medical Devices Laboratory  Samples Repository  Licensing and Enforcement  Other (*specify***)**…………………………………….. |
| **4. How did we provide the service?**  ***Please tick where applicable***  **phone  website  letter  email  face to face**  **Other** (*specify)*……………………………………. |
| **5. When did we provide the service?**  Date of service ……………………………. Time……………………. |

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| ***Please tick where applicable***  **6. How do you rate the service rendered to you?** | 5  Excellent | 4  Good | 3  Fair | 2  poor | 1  Very Poor |
|  |  |  |  |  |
| **7. How was the professional conduct of staff that served you?** |  |  |  |  |  |
| **8. How do you rate your experience with us** |  |  |  |  |  |
| **9.Comments and/ or suggestions:**  *What can we do to improve your experience?*  *What else would you like us to know?* | | | | | |
| **10.Customer details** (*Optional*) | | | | | |
| Customer Name: | | | | | |
| Contacts: Phone Number: E-mail: | | | | | |
| Date of feedback submission: | | | | | |

*NB: Form to be dropped into the suggestion box at MCAZ reception or as mail, Medicines Control Authority of Zimbabwe 106 Baines Avenue P O Box 10556 Harare Zimbabwe.*

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| **For MCAZ use only**  Total Score /15 Total Score: …………………………..%  Form Evaluated by: \_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name Signature Date |