TITLE	CUSTOMER FEEDBACK FORM

Topic: Customer Feedback	Customer Name:
Place:	Date:
Name of the Product:	Batch No.

Your feedback is valuable and remains confidential. Kindly tick the appropriate section for rating

1. Functionality of the device Poor ( ) Average ( ) Good ( ) Very Good ( ) Excellent ( )
2. Easy to handle Poor ( ) Average ( ) Good ( ) Very Good ( ) Excellent ( )
3. Aesthetic look of device Poor ( ) Average ( ) Good ( ) Very Good ( ) Excellent ( )
4. Information provided in leaflet for dose administration is useful or not Poor ( ) Average ( ) Good ( ) Very Good ( ) Excellent ( )

Overall customer satisfactory level:

Poor ( ) Average ( ) Good ( ) Very Good ( ) Excellent ( )

Any Other Comments/ Feedback

Customer Name: _____

Signature and Date: _____

Acknowledged by Wockhardt Representative

Name: _____

Signature & Date: _____