TITLE	CUSTOMER FEEDBACK FORM

Customer Name:	
Place:	
Name of the Product:	
Date of Report:	
Batch No:	
Manufacturing Date:	
Expiry Date:	

Thank you for sharing your experience with medical device. This short form takes about 3 minutes to complete. Completion is voluntary.

Section A — About You

A1. I am completing this form as a: ☐ Patient (self-administering) ☐ Caregiver (administering on behalf of a patient) ☐ Healthcare Professional (HCP)

A2. Age of the person using the medical device: _____Years

Age band: ☐ 12–17 (adolescent) ☐ 18–64 (adult) ☐ 65+ (older adult)

A3. Sex / gender: _____

A4. Country: _____

A5. Type of diabetes (**for insulin device only**): ☐ Type 1 ☐ Type 2 ☐ Other / not sure

A6. How long have you (or the patient) been using devices?

☐ Less than 6 months ☐ 6 months–2 years ☐ Over 2 years

A7. Is this the first insulin pen device you have used, or have you used other pen devices before? (for insulin device only)

☐ First device (naïve user) ☐ Used other devices before (experienced user)

A8. Is this the first device/kit you have used, or have you used other device/kits before?

☐ First time (naïve user) ☐ Used other devices/kits before (experienced user) (for non-insulin device only)

Section B — Your Experience with device

B1. Overall, how satisfied are you with device/ device handling?

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

B2. How satisfied are you that you are setting/delivering the correct insulin dose? (for insulin device only)

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

B3. How is the functionality of device?

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

B4. Aesthetic Look of the device

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

B5. Information provided in the leaflet

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

B6. Have you experienced any difficulty reading the dose display, handling, or operating the device? Any comments, suggestions, you would like the manufacturer to know about ☐ No ☐ Yes — please describe: _____

Section C — Consent and Submission

☐ I understand this information will be used by the manufacturer for post-market safety and performance monitoring (PMCF) purposes. and that submission is voluntary.

☐ I would like to be contacted for follow-up about my feedback (optional). If checked, contact email/phone: _____

How to Submit This Form?

- Assisted: Contact the manufacturer's Pharmacovigilance Safety Toll-Free Helpline: 1800-258-8127 (Available 24 hours, 7 days a week, Free of charge and a representative will record your report on your behalf.
- This paper version may also be photographed/scanned and emailed to pv.safety@wockhardt.com, or given to your HCP or pharmacist to submit on your behalf.

Manufacturer internal use only

Date received: _____

Logged by: _____