



CLIENT SATISFACTION SURVEY AUTHORIZATION

Upon completion of counseling sessions with your clinician from the DEA Employee Assistance Program (EAP), we would like feedback regarding your satisfaction with the services you have received. With your permission, the DEA EAP Contractor will contact you by telephone to conduct a five minute survey.

The information collected will be used to improve the quality of our services to DEA employees and their family members.

Your responses will be confidential and never be linked to you in any way.

If you are willing to participate in the survey, please indicate this by filling out the information requested below and return it to your EAP Clinician immediately. If you do not wish to participate in the survey, please write your name on the first line and check the box at the bottom of the page.

The choice is completely yours. Thank you for your assistance.

Clinician's Name: _____

Your Name: _____

Telephone number to call: _____

Best time to reach you: _____

Signature: _____

Date: _____

☐ I Do Not Wish To Be Contacted