



### Physician Wellness Program Evaluation

Client Feedback, anonymous or otherwise, is important for us to continue to improve, enhance, and market this program. Thank you for your time

1. How did you learn or hear about the Physician Wellness Program? \_\_\_\_\_

2. How many sessions did you utilize during this benefit period you are evaluating? \_\_\_\_\_

3. The challenges or situation that brought you to the PWP are:

Much improved      Improved      About the same      Worse      Much worse

4. How easy was it for you to find a PWP provider that could address your needs and schedule with you in a timely manner and in a convenient location?

Very easy      Somewhat Easy      Somewhat Difficult      Very Difficult

PWP Providers Name (optional) \_\_\_\_\_

5. Was your PWP provider:

Very helpful      Somewhat helpful      Somewhat unhelpful      Very unhelpful

Comments or details you would like to share: \_\_\_\_\_

6. Because of your PWP participation, do you think you are better equipped to manage challenges in the future?

Strongly agree      Agree      Uncertain      Disagree      Strongly disagree

7. If you knew a colleague who needed help in the future, would you feel comfortable recommending them to the Physician Wellness Program.

Definitely yes      Probably yes      Maybe      Probably not      Definitely not

8. Is there anything you learned, resources or tools you utilized, you would encourage others who may be struggling to explore?

9. Do you have any other comments or suggestions you would like to share (Biggest challenge with the program or greatest benefit from using the program):  
\_\_\_\_\_

(Optional) If you are willing to be quoted for what the program has meant to you so we can market it better, please let us know.

You may quote me by  name /  licensure /  specialty Details \_\_\_\_\_

NO – PLEASE USE FOR INTERNAL EVALUATION ONLY

Please print and return to 850 Ridge Avenue Pittsburgh, PA 15212 or email [mmayer@acms.org](mailto:mmayer@acms.org)