

## Off-Site Influenza Clinic Evaluation Form 2009-2010

DATE:

DATE/TIME OF OUTREACH:

SITE NAME:

CLINIC MANAGER:

SITE ADDRESS:

1. WAS THIS A GOOD SITE FOR THE CLINIC? YES  NO

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

2. WAS AMOUNT OF VACCINE PROVIDED ADEQUATE? YES  NO

If no, number of people turned away: \_\_\_\_\_

Total number of people immunized at this outreach: \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

3. WAS THERE AN ADEQUATE NUMBER OF VOLUNTEERS?

Support Staff: YES  NO  Number: \_\_\_\_\_

Nursing: YES  NO  Number: \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

4. WERE SUPPLIES ADEQUATE? YES  NO

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

5. WHAT PROBLEMS WERE ENCOUNTERED? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOW COULD THESE PROBLEMS BE RESOLVED? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. WOULD YOU RECOMMEND THIS SITE FOR NEXT YEAR? YES  NO

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

**PLEASE KEEP THIS FORM FOR PLANNING NEXT YEAR'S INFLUENZA CAMPAIGN**