**Any Medical Society**

**Physician Wellness Program Participant Survey**

The information collected on this form is useful for AMS to know how to best provide services to our members. Please mail completed form to the Medical Society in the envelope provided. To protect your identity, do not sign or add a return address.

❒ First Time Session ❒ Follow-Up Session Date of Session\_\_\_\_\_\_\_\_\_

**Please tell us about your experience with the AMS Coaching Program:**

1. Who was your counselor?
2. Accessing the program and getting set up with the counselor went well. ❒Yes ❒ No
3. The counselor was able to offer me an appointment time the worked for me. ❒Yes ❒ No
4. The location was convenient. ❒ Yes ❒ No
5. The counselor was easy to talk to. ❒ Yes ❒ No
6. My meetings with this counselor have been helpful. ❒ Yes ❒ No
7. I plan to continue seeing this counselor. ❒ Yes

 ❒ No, was not satisfied with visit. ❒ No, services no longer needed.

1. I would recommend this counselor to my colleagues or patients. ❒ Yes ❒ No
2. I am confident that confidentiality is being maintained. ❒ Yes ❒ No ❒ Not sure
3. Additional comments or suggestions:

**Basic Demographics**

❒ Age 25-45 ❒ Age 45-65 ❒ Age 65+

❒ Male ❒ Female

❒ Physician ❒ Spouse or Partner