

BALLARD™ 7DAY CLOSED SUCTION SYSTEM

DATE _____

FACILITY / HOSPITAL _____

NAME + TITLE _____

DEPARTMENT _____



Please provide your feedback on the Ballard™ 7Day Closed Suction System.
Put an "X" in the box that best describes your answer and include any additional comments that you may have in the space on the right.

EVALUATION CRITERIA	AGREE	DISAGREE	N/A	COMMENTS
I was able to effectively perform closed suction using the Ballard 7Day Closed Suction System.				
The Ballard 7Day Closed Suction System was easy to use.				
I saw consistent performance and cleaning action in the isolated cleaning chamber.				
I was able to use the Ballard 7Day Closed Suction System as intended.				
I recommend that my hospital use the Ballard 7Day Closed Suction System.				

ADDITIONAL COMMENTS:

Thank you for participating in this trial. Please return your evaluation form to: _____