HOSPITAL PERFORMANCE MEASUREMENT CHECKLIST

(BI-ANNUAL)

PERFORMANCE MEASURING CHECKLIST

Name of in charge: ______________________ Designation: ______________

Date of inspection: ______/________/________ Time:

Views	Number of persons contacted in OPD/ Field	PUBLIC OPINION			
		Good	Average	Unsatisfactory	No Response
1) Presence of Doctors/Staff					
2) Attitude of staff towards patients					
3) Waiting Time					

Note: Names and Contact Numbers of at least two persons interviewed during the visit

Sr. No.	Name	Address	Contact Number

GENERAL REMARKS

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