Practitioner Name /Company Name: _____

Date: _____

Aerosol Assist Practitioner Survey

We would like your help evaluating the Aerosol Assist by offering us your honest feedback. When we all work together as one we can truly accomplish great things.

Please rate the following on a scale of 1 to 10, ((1- Strongly Disagree| 10- Strongly Agree)

1. Insertion process of the Aerosol assist was easy _____
2. Helped patients with TMJ issues; limited ability to open _____
3. Helped patients with pharyngeal or gag reflex _____
4. Working space was not compromised by using device _____
5. Visibility was not compromised by using this device _____
6. Set-Up was Easy _____
7. Cleaning process was easy _____
8. Made me feel safer _____
9. It was easy to change from side to side _____
10. The Aerosol Assist was stable _____
11. Adjusting the quick connect adequately relieves torque and properly positions the Aerosol Assist. _____
12. The Aerosol Assist provided adequate saliva extraction _____
13. The Aerosol Assist visually reduced Aerosols _____
14. The Aerosol Assist visually reduced splatter _____
15. The Aerosol Assisted helped keep the patients bib dry _____
16. The Aerosol Assisted helped keep the patients face was kept dry _____
17. The Aerosol Assisted helped keep the patient's neck dry _____
18. The Aerosol Assisted helped keep the Chair dry _____
19. The Aerosol Assisted helped keep my PPE clean/dry _____

Please tell us what you liked best and least about this product:

_____

_____

_____