USER SURVEY

To be completed by all parties and their representatives at end of mediation conference and returned to Sharing Neutrals Program, HHS Departmental Appeals Board Human Services, fax (202) 565-0223, within five business days of the close of mediation.

Name of Mediator(s): _____ and _____

Agency Requesting Mediation Services: _____

Check one: Initiating party ___ Responding party ___ Representative ___ Other ___

Date(s) of Mediation: _____

Outcome: Resolved ___ Not Resolved ___ Other (explain) _____

Type of Case, (e.g., EEO, general workplace, contract dispute):_____

Your input is important, it tells us how we are serving you.

1) Did the mediator(s) explain the process clearly to all parties?

2) Did the mediators listen to you?

3) Were the mediators impartial?

4) Did the mediation improve your understanding of the issues?

5) Were you satisfied with the outcome of the mediation? Why?

6) Did you feel that you were able to make decisions for yourself?

USER SURVEY—CONTINUED

7) Would you use mediation again in the future? Why?

8) Was it helpful to have a mediator from another federal agency?

THANK YOU!

Your responses will be used for evaluation purposes only.