

**DOC Pharmaceutical  
Services RFP Vendor  
Reference Survey**

Vendor Applicant: \_\_\_\_\_

Reference Company Name: \_\_\_\_\_

Reference Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

1. How long has your company been a client of the vendor?

\_\_\_\_\_

2. How would you rate the vendor in each of the following categories or services? If you have not received a service, please respond N/A.

- |   |   |   |   |   |   |     |
|---|---|---|---|---|---|-----|
| a. Customer service   | 1 | 2 | 3 | 4 | 5 | N/A |
| b. Overall account management   | 1 | 2 | 3 | 4 | 5 | N/A |
| c. Prescription fill accuracy   | 1 | 2 | 3 | 4 | 5 | N/A |
| d. Timeliness of shipping   | 1 | 2 | 3 | 4 | 5 | N/A |
| e. Ability to meet special labeling/packaging requirements            | 1 | 2 | 3 | 4 | 5 | N/A |
| f. Internal control measures for preventing harmful drug interactions | 1 | 2 | 3 | 4 | 5 | N/A |
| g. Other services (please specify)                                    | 1 | 2 | 3 | 4 | 5 | N/A |

- |                    |
|--------------------|
| 1 – Poor           |
| 2 – Unsatisfactory |
| 3 – Neutral        |
| 4 – Satisfactory   |
| 5 – Excellent      |

3. How likely are you to use the vendor again?

- a. Will not use them again
- b. Not likely
- c. Neutral
- d. Likely
- e. Highly likely