

# Community Response Form

Name (optional):	
Address (optional):	
City:	State:
Phone (optional):	
Email (optional):	
Date:	
Project:	
Project Goal:	
<i>Check the box that answers the below statements:</i>	
1. I understand the goal of this project.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I think this project addresses a real community health need.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. This health need is among the most important in our community.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I think that the community benefited from this service project.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. As a result of this project, the community will become more conscious of its health.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. I would like to be engaged in future efforts to improve the health of my community.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments or Suggestions:	

