

TOP Medical Clinic



Please complete this form to share your experience with us.

Doctor's Name : *Kołodziejczak*

Date of Visit: *28/04/16*

Feedback (please be specific):

*Very knowledgeable; good service; informative
helpful; will come back again*

Suggestions for change or improvement:

none

Signature (Optional) *[Signature]*

Thank you for allowing us to serve you