

Requisitioner's Name	Department / Panel
Requisitioner's Signature	Deliver Printed Questionnaires To

ITEM REQUISITION GRID

Enter the ACCESS catalog question numbers and/or Block-ids corresponding to those items that you wish to include in the student feedback questionnaire.

Please refer to the ACCESS catalog for appropriate questions.

7004	7005	7006	7007	7008	7009	7010	7011	270
7012	7013	7020	7014	7015	7016	7017	7018	7019
812	813	1	2	3	4	5	6	7
8	9	10	11	12	13	14	15	16

- ◆ For unique question(s), i.e. which does not appear in the ACCESS catalog, please write them on the "Unique Question Attachment" form.
- ◆ For multiple classes using the same set of questions: please use the "Class-Identification" form to provide information for each class.
- ◆ For team teaching activities: please use the "Team Teaching" form, listing the instructors who comprise one team and identify the question that should be repeated for each instructor.

Instructor's Name: (to be shown on questionnaire) _____

Department / Panel: (to be shown on questionnaire) _____

Course / Class: (to be shown on questionnaire) _____

Module / Section: (to be shown on questionnaires) _____

Year of Program: _____ **Protocol:** _____
(Lecture / Laboratory or Tutorial / Bedside Teaching)

No. of Questionnaires Required: _____ **Date Questionnaires Are Required:** _____

Report(s) required:	Reference Group: cross (x) the type(s) you wish to use:
<input type="checkbox"/> Instructor Report	<input type="checkbox"/> All classes in the Faculty of Medicine (default) <input type="checkbox"/> All classes in the Department / Panel <input type="checkbox"/> Same Year <input type="checkbox"/> Similar Protocol <input type="checkbox"/> Academic Year
<input type="checkbox"/> Aggregate Report	<input type="checkbox"/> All classes in the Faculty of Medicine (default) <input type="checkbox"/> All classes in the Department / Panel <input type="checkbox"/> Same Year <input type="checkbox"/> Similar Protocol <input type="checkbox"/> Academic Year

Send Reports to:

- ☐ Chair (name specified) -
- ☐ Requisitioner (name specified) -
- ☐ Corresponding instructor(s) (name specified) -
- ☐ Others (specified) -

Mailing Address: _____

Date of Reports Required: _____

No. of pages attached to this Request Form: _____

Mail this Request Form with any attached pages to:

OES – Ms Diana Kwan, Flat 9A, Block B, Staff Quarters, Prince of Wales Hospital (Telephone: 2145-5233)

CLASS IDENTIFICATION FORM: To ACCESS Request # _____

*For **multiple classes** that use the same set of questions, please use this form to provide information of each class.*

[illegible]

TEAM TEACHING FORM: To ACCESS Request # _____

For **team teaching** activities, please use this form to list out the instructors of the team and identify questions, which will be repeated for each instructor.

[illegible]

UNIQUE QUESTION FORM: To ACCESS Request # _____

Please provide on this form the “write-in” questions that you wish to add to the ACCESS questionnaires. Each line may have a maximum of 92 characters, including punctuation and spaces. Please remember to write in the Request Number (above).

[illegible]