



Caster Application Questionnaire
PLEASE FAX THIS COMPLETED FORM TO: 1-517-686-1072

Organization: (optional) _____

Application: Hospital Clean room Pharmaceutical Food equip/service
 Furniture Laundry Other (please specify) _____

What kind of equipment do you use which requires casters? (check all that apply)

laundry carts stretchers/beds medicine carts maintenance carts
 IV poles potty chairs patient lifts wheelchairs
 foodservice carts shower chairs other: _____

When choosing a caster for your equipment, how important are these features?
(1 = not important at all; 10 = extremely important)

| | | | | | |
|--------------------------|-------|---------------------|-------|-----------|-------|
| Easy to push/pull | _____ | Low Maintenance | _____ | Low Noise | _____ |
| Straight line rolling | _____ | Appearance | _____ | | |
| Sterilization/steam wash | _____ | Overall performance | _____ | | |

What do you like about the casters currently used on your equipment?

What do you dislike about the casters currently used on your equipment?

How do you rate the casters currently on your equipment in these categories?
(1 = unacceptable; 10 = excellent)

| | | | | | |
|--------------------------|-------|---------------------|-------|-----------|-------|
| Easy to push/pull | _____ | Low Maintenance | _____ | Low Noise | _____ |
| Straight line rolling | _____ | Appearance | _____ | | |
| Sterilization/steam wash | _____ | Overall performance | _____ | | |

What improvements would you like to see made to the casters currently on your equipment?

What about added options?

Thank you for taking the time to complete and return this survey. The information gathered will remain confidential and only be used for statistical market analysis.