SAFETY FEATURE EVALUATION FORM
DENTAL SAFETY GLASSES

Date: _____ Department: _____ Occupation: _____

Product: _____ Number of times used: _____

Please **circle** the most appropriate answer for each question. Not applicable (N/A) may be used if the question does not apply to this particular product.

agree.....disagree

1. The product **does not** fog up.....1 2 3 4 5 N/A
2. The product works well with a variety of head sizes.....1 2 3 4 5 N/A
3. The product is light weight.....1 2 3 4 5 N/A
4. The product **does not** distort vision.....1 2 3 4 5 N/A
5. The product is comfortable to wear for extended periods of time.....1 2 3 4 5 N/A
6. The product can be used while wearing presecription glasses.....1 2 3 4 5 N/A
7. The product can be used while wearing loupes.....1 2 3 4 5 N/A
8. The product offers side protection.....1 2 3 4 5 N/A

Of the above questions, which three are the most important to **your** safety when using this product?

Are there other questions which you feel should be asked regarding the safety/ utility of this product?

Training for Development of Innovative Control Technology Project