

**Form Approved  
OMB No.  
Expiration Date:**

## **Attachment 5a**

### **Provider Recruitment Materials**

#### **<<Health Care Provider Verification Form>>**

Public reporting burden of this collection of information is estimated to average 17 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or an other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

Provider ID number: 123456 Dr. John Doe

Thank you for agreeing to participate in the Registry for Unexplained Fatiguing Illnesses and CFS. We would like to confirm some basic information about your practice. Please answer the following questions and return this form in the pre-paid business envelope.

Do you currently treat or diagnose patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you practice in Bibb County?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please list your health care specialties (e.g., pediatrics, physical therapy, psychology, OB-GYN)	Enter Specialties here:	
Do you practice exclusively in a military facility, correctional facility, nursing home facility, or in a mental health hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What proportion of your practice is with adolescents (patients age 12-17)?	Enter percentage: _____%	

For the address listed below, please update the address and phone information and tell us whether you would like patient recruitment materials sent to you or to someone else. Please add additional offices where you see patients.

Practice Name and Address	This address is... (Please check all that apply.)		If this is an office where you see patients/clients, please name the person at this location who can serve as the point of contact about study matters.
Practice: _____ Address 1: _____ Address 2: _____ City/ST/ZIP: _____ Phone _____	<input type="checkbox"/> Home address  <input type="checkbox"/> Office where I see patients/clients  <input type="checkbox"/> Other office where I do not see patients/clients  <input type="checkbox"/> Former/incorrect address	<input type="checkbox"/> Military clinic  <input type="checkbox"/> Correctional facility  <input type="checkbox"/> Inpatient mental health facility  <input type="checkbox"/> Nursing Home	<input type="checkbox"/> Contact me directly  <input type="checkbox"/> Contact the following person: Name: _____  Phone: (____) _____

**See reverse side for additional addresses**

Practice Name and Address	This address is... (Please check all that apply.)		If this is an office where you see patients/clients, please name the person at this location who can serve as the point of contact about study matters.
Practice: _____ Address 1: _____ Address 2: _____ City/ST/ZIP: _____ Phone _____	<input type="checkbox"/> Home address  <input type="checkbox"/> Office where I see patients/clients  <input type="checkbox"/> Other office where I do not see patients/clients  <input type="checkbox"/> Former/incorrect address	<input type="checkbox"/> Military clinic  <input type="checkbox"/> Correctional facility  <input type="checkbox"/> Inpatient mental health facility  <input type="checkbox"/> Nursing Home	<input type="checkbox"/> Contact me directly  <input type="checkbox"/> Contact the following person: Name: _____  Phone: (____)_____
Practice: _____ Address 1: _____ Address 2: _____ City/ST/ZIP: _____ Phone _____	<input type="checkbox"/> Home address  <input type="checkbox"/> Office where I see patients/clients  <input type="checkbox"/> Other office where I do not see patients/clients  <input type="checkbox"/> Former/incorrect address	<input type="checkbox"/> Military clinic  <input type="checkbox"/> Correctional facility  <input type="checkbox"/> Inpatient mental health facility  <input type="checkbox"/> Nursing Home	<input type="checkbox"/> Contact me directly  <input type="checkbox"/> Contact the following person: Name: _____  Phone: (____)_____
Practice: _____ Address 1: _____ Address 2: _____ City/ST/ZIP: _____ Phone _____	<input type="checkbox"/> Home address  <input type="checkbox"/> Office where I see patients/clients  <input type="checkbox"/> Other office where I do not see patients/clients  <input type="checkbox"/> Former/incorrect address	<input type="checkbox"/> Military clinic  <input type="checkbox"/> Correctional facility  <input type="checkbox"/> Inpatient mental health facility  <input type="checkbox"/> Nursing Home	<input type="checkbox"/> Contact me directly  <input type="checkbox"/> Contact the following person: Name: _____  Phone: (____)_____
Practice: _____ Address 1: _____ Address 2: _____ City/ST/ZIP: _____ Phone _____	<input type="checkbox"/> Home address  <input type="checkbox"/> Office where I see patients/clients  <input type="checkbox"/> Other office where I do not see patients/clients  <input type="checkbox"/> Former/incorrect address	<input type="checkbox"/> Military clinic  <input type="checkbox"/> Correctional facility  <input type="checkbox"/> Inpatient mental health facility  <input type="checkbox"/> Nursing Home	<input type="checkbox"/> Contact me directly  <input type="checkbox"/> Contact the following person: Name: _____  Phone: (____)_____