Form Approved
OMB No.
Expiration Date:

Attachment 5a

Provider Recruitment Materials

<<Health Care Provider Verification Form>>

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?	☐ Yes	☐ No
Do you practice in Bibb County?	☐ Yes	☐ 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?	☐ Yes	☐ 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 _____	☐ Home address ☐ Office where I see patients/clients ☐ Other office where I do not see patients/clients ☐ Former/incorrect address	☐ Military clinic ☐ Correctional facility ☐ Inpatient mental health facility ☐ Nursing Home	☐ Contact me directly ☐ 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 ________________________	☐ Home address ☐ Office where I see patients/clients ☐ Other office where I do not see patients/clients ☐ Former/incorrect address	☐ Military clinic ☐ Correctional facility ☐ Inpatient mental health facility ☐ Nursing Home	☐ Contact me directly ☐ Contact the following person: Name:________________________ Phone: (____)__________
Practice:________________________ Address 1:_______________________ Address 2:______________________ City/ST/ZIP:________________________ Phone ________________________	☐ Home address ☐ Office where I see patients/clients ☐ Other office where I do not see patients/clients ☐ Former/incorrect address	☐ Military clinic ☐ Correctional facility ☐ Inpatient mental health facility ☐ Nursing Home	☐ Contact me directly ☐ Contact the following person: Name:________________________ Phone: (____)__________
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