ATTACHMENT F:

PHYSICIAN RESPONSE FORM

Form Approved
OMB No. 0920-XXXX
Expiration Date:

Physician Response Form

Physician Cancer Screening Discussion Response Form

Please confirm the following information about yourself and your practice:

1. What is your medical specialty (*the specialty in which you spend 50% or more of your professional time*):
   ❑ Family Physician ❑ General Internist
   ❑ General Practitioner ❑ Other *(please specify):*____________________

2. On average, how many hours per week do you spend in direct patient care? ______ hours

3. Which best describes the setting in which you practice?
   ❑ Solo practice ❑ Staff Model Health Maintenance

   Organization (HMO)
   ❑ Single specialty group practice ❑ Other model HMO, Managed Care

   Organization (MCO)
   ❑ Multi-specialty group practice ❑ Mixed model practice
   ❑ Other *(please specify):* ___________________________

4. Do you conduct health maintenance examinations? ❑ Yes ❑ No

5. Does your practice setting have formal cancer screening guidelines? ❑ Yes ❑ No

6. Do you have an academic appointment at a Medical School? ❑ Yes ❑ No

7. Your Gender: ❑ Male ❑ Female

7. Are Hispanic/Latina?
   a) Yes
   b) No

Public reporting burden of this collection of information is estimated to average 5 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 any 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)

8. How would you describe your race?

[DO NOT READ OPTIONS. OK if person gives more than one response. If multiple responses include “white” or “Caucasian,” count as “other.” “Bi-Racial” record as other.]

1	White or Caucasian	**[Continue]**
2	Black or African American	**[Continue]**
3	Native Hawaiian or Other Pacific Islander	**[Continue]**
4	Asian	**[Continue]**
5	American Indian or Alaska Native	**[Continue]**
6	Other: ________________	**[Continue]**

Please indicate your interest in participating in the group discussion.

❑ **I am not interested in participating, please do not contact me.**

❑ **I am interested in participating and my preferences are listed below.**

- ❑ Alternate Date 1
- ❑ Alternate Date 2
- ❑ Alternate Date 3
- ❑ Alternate Date 4
- ❑ Alternate Date 5
- ❑ Alternate Date 6

❑ **I am interested in participating, but unable to make any of the dates.**

Please provide the best telephone number to reach you during those times:

Your telephone number: (______)________________________

Please provide your fax number or e-mail address so we can send you confirmation by fax, e-mail, or mail:

Your fax number: (____________________________________)

Your e-mail address: ____________________@____________________________

Please provide the mailing address to which your compensation check should be mailed upon completion of your participation:

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You may:
1) Fax this form to us using the enclosed Fax Cover Sheet, OR
2) Mail this in the enclosed postage-paid envelope

Please call or e-mail Cindy Soloe, RTI Study Coordinator, at csoloe@rti.org or 919-316-3363 if you have any questions.

Thank you for your time.