Study barcode ID

Form Approved OMB No. 0920-xxxx Exp. xx/xx/xxxx

CDC CERVICAL CANCER STUDY (Cx3 Study)

Patient Enrollment Form - [CLINIC NAME]

First Name:	Last Name:			
Date of Birtl	n: month	year		
		3=[Provider3] 4=[Provider4]	5=[Provider5] 6=[Provider6]	
Selected for	Patient Survey:	Yes / No Co	nsented to Patient	Survey: Yes / No
				the following section:
PATIENT CO	ONTACT INFORM	ATION:		
Address:				
Phone numl				
Work:		Cell: _		
			r who will always ki ng trouble contacti	now where to contact ing her.
Name of Fri	end or Relative:			
Telephone N	Number of Friend	or Relative:		
	Type of pl	hone (circle): Ho	me / Work / Ce	ell

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 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 E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)