NORC at the UNIVERSITY of CHICAGO

DOWNTOWN CHICAGO
55 East Monroe Stree
30th Floo
Chicago IL 60603
office (312) 759-400(
fax (312) 759-400
www.norc.org

Health Care Provider Record Verification Form

Date (MM/DD/YY) ____/_____/_____

Parent/Guardian Name: _____

Please indicate whether you treated and/or diagnosed _____with the following
Child's Name
conditions. If yes, please enter the date(s) of treatment and/or diagnosis.

Condition	Date Treated and/or Diagnosed	Yes	No
a.		❑	❑
b.		❑	❑
c.		❑	❑
d.		❑	❑
e.		❑	❑
f.		❑	❑
g.		❑	❑
h.		❑	❑
i.		❑	❑
j.		❑	❑
k.		❑	❑

Please sign and date below:

_____

Signature *Date*

Completed forms should be returned to NORC by fax (xxx)-xxx-xxxx or mail: 55 E. Monroe Street, Suite 30, Chicago, IL 60603.

Thank you for your participation in this important study!

Mode: Mail