NORC at the UNIVERSITY of CHICAGO

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Health Care Provider Record Verification Form

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

Interviewer Name: _____

Respondent ID: _____

Provider Name: _____
**If someone other than the provider completed the interview, please indicate in the comment box below.*

Have you treated and/or diagnosed _____with the following conditions. If yes, what
Child's Name
are 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.		❑	❑

COMMENTS: