QUALITY CONTROL FORM

NOTICE: Public reporting burden (or time) for this collection of information is estimated to average 2 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PRAstaff@FDA.HHS.GOV. 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. The OMB control number for this project is 0910-XXXX.

OMB No.:

OMB Expiration Date:

As part of our quality control program, we plan to contact a portion of the survey participants to make sure that the interviewer has followed the study procedures. We only ask general questions—no specific information is required. We sincerely appreciate your cooperation.

Please fill in the boxes below. (PLEASE PRINT CLEARLY.) **Thank you.**

[Your phone number will be kept private and will not be released to anyone other than our quality control representatives.]

TELEPHONE NUMBER				–				–				
	(Area Code)				**(Telephone Number)**							

YOUR ADDRESS	

CITY		**STATE**			**ZIP CODE**					

BOXES BELOW MUST FIRST BE COMPLETED [IN INK] BY INTERVIEWER.

TODAY'S DATE	M	M	–	D	D	–	1	5	**TIME**			**:**			AM PM

FI NAME		**FI ID #**						

CASE ID #							–		–				–		**Include A or B!**

IF respondent is 12 - 17 years old, which adult granted permission for the interview? → (Examples: father, mother, etc.)	[Print Parent/Guardian's relationship to the child in this box.]