

Form Approved
OMB No. 0920-New
Expiration Date: XX/XX/XXXX

**mChoice: Improving PrEP Uptake and Adherence among Minority MSM through
Provider Training and Adherence Assistance in Two High Priority Settings**

**Attachment 4h
Provider Locator Form**

Public reporting burden of this collection of information is estimated to average 10 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: OMB-PRA (0920-New)

Locator Form

Date form completed or updated: _____(mm/dd/yyyy)

Fill out as much tracking information as possible. You may withhold certain pieces of data that you choose not to share.

Information collected on this form will be used to contact you when it is time to complete a study visit (i.e. meeting with your practice coach, clinic assessment tool or follow-up interview). The information that you provide will be kept in a separate place from the answers to any questions that you have provided. It will only be used to locate you during the study period and will not be given to anyone else. If we reach out through a phone call, and you are not the one who picks up the phone, we will not share any information about your participation in the study. We will simply identify ourselves and provide you with a callback number. May we have the following information and your permission to use the information to try to contact you?

Participant Information

Participant's full legal name:

First: _____

Middle: _____

Last: _____

Nickname/Preferred Name: _____

Preferred Pronoun: _____

Clinic:

- ☐ Birmingham AIDS Outreach
- ☐ University of Alabama at Birmingham 1917 Clinic
- ☐ Callen-Lorde Community Health Center
- ☐ Columbia University Nurse Practitioner Primary Care Group

Participant's home address:

Number and street: _____

City or town: _____ State: _____ Zip Code: _____

Can we send you information at this address? _____ No _____ Yes

Participant's contact information:

Primary phone number (xxx-xxx-xxxx): _____

Type:

- ☐ Home phone
- ☐ Cell phone
- ☐ Message phone

If you are not available, is it okay to leave a message at this number regarding the research project?

___ No ___ Yes

If yes, what can the message say?

Secondary phone number (xxx-xxx-xxxx): _____

Type:

- ☐ Home phone
- ☐ Cell phone
- ☐ Message phone

If you are not available, is it okay to leave a message at this number regarding the research project?

___ No ___ Yes

If yes, what can the message say?

Other phone number (xxx-xxx-xxxx): _____

Type:

- ☐ Home phone
- ☐ Cell phone
- ☐ Message phone

If you are not available, is it okay to leave a message at this number regarding the research project?

___ No ___ Yes

If yes, what can the message say?

Can we send you a text message to a cell phone to remind you about your study visits?

___ No ___ Yes ___ N/A (no access to a cell phone)

If "Yes", cell phone number (xxx-xxx-xxxx): _____

Primary email address:

Type:

- ☐ Personal email
- ☐ Work email
- ☐ Friend/family member email

Can we email you to remind you of study visits? ___ No ___ Yes ___ N/A

Secondary email address:

Type:

- ☐ Personal email
- ☐ Work email
- ☐ Friend/family member email

Can we email you to remind you of study visits? ___ No ___ Yes ___ N/A

Other email address:

Type:

- ☐ Personal email
- ☐ Work email
- ☐ Friend/family member email

Can we email you to remind you of study visits? ___ No ___ Yes ___ N/A