A. VERIFICATION OF IDENTIFYING INFORMATION

1. a~ Title: ____ ▓   b~ First Name: _____ ▓

    c~ Middle Name: _____ ▓   d~ Last Name: _____ ▓

2. Mailing Address: a~ _____ ▓
                      b~ _____ ▓
                      c~ _____ ▓

    d~ City: _____ ▓   e~ State: __ ▓   f~ Zip Code: _____ ▓

3~ Home Phone Number: _____ ▓   4~ Other Phone Number: _____ ▓
                      area-###-####   area-###-####

5~ If missing, request Social Security Number: _____ ▓
   {Show disclosure statement}   ###-##-####

6~ Administrative use: _____ ▓

B. CONTACT PERSON 1

    {Press Esc-2 to produce explanatory statement before proceeding.}

7. a~ Title: ____ ▓   b~ First Name: _____ ▓

    c~ Last Name: _____ ▓

8. Mailing Address:

    a~ _____ ▓
    b~ _____ ▓
    c~ _____ ▓

    d~ City: _____ ▓   e~ State: __ ▓   f~ Zip Code: _____ ▓

9~ Telephone: _____ ▓   10~ Relationship: _____ ▓
              area-###-####

C. CONTACT PERSON 2

11. a~ Title: ____ ▓   b~ First Name: _____ ▓

    c~ Last Name: _____ ▓

12. Mailing Address:

    a~ _____ ▓
    b~ _____ ▓
    c~ _____ ▓

    d~ City: _____ ▓ e~ State: __ ▓ f~ Zip Code: _____ ▓

13~ Telephone: _____ ▓
                 area-###-####

14~ Relationship: _____ ▓

D. PHYSICIAN INFORMATION

15. a~ First Name: _____ ▓

     b~ Last Name: _____ ▓

16. a~ Clinic/Building: _____ ▓

     Mailing Address:

     b~ _____ ▓
     c~ _____ ▓

     d~ City: _____ ▓ e~ State: __ ▓ f~ Zip Code: _____ ▓

E. ADMINISTRATIVE INFORMATION {Show and explain Results Reporting Sheet.}

17~ Our usual procedure is to send results to you and your
     physician as shown on this sheet.   _ ▓

  {Enter "U" unless participant has no personal physician or volunteers that
     this procedure is not satisfactory. If no physician, enter "T". If
     participant requests another procedure, offer those given below.}

     Usual procedure (detailed results to physician, summary to participant)   U

     Detailed results to participant, but not to physician   T

     Detailed results to both participant and physician   B

18~ Date of data collection/update: _____ ▓
                                     mm/dd/yy

19~ Code number of person completing/updating this form: ___ ▓