Name:	**Date Completed**
_____	___/___/____

Study Name: Collaborative Specialty Care for Gulf War Illness
Form Name: Mental Health Care Provider Notification form

We encourage all participants to talk with their mental health providers about their participation in this study. Please check appropriate statement below.

_____ I am not currently in mental health treatment.

_____ I am in mental health treatment and I will talk to my mental health provider about my participation in this study.

_____ I am in mental health treatment and I decline to talk to my mental health provider about my participation in this study.

_____ I am in mental health treatment and would like you to contact my mental health provider about my participation in this study. Below is his/her information:

Name _____

Phone Number _____

Address _____

If you would like us to contact your mental health provider, we will mail a letter to the address you provide. We encourage you to also talk with him/her.

_____ _____

Your Signature Date