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

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

We encourage all participants to talk with their primary health care providers about their participation in this study. We will also send a letter to your primary care provider to notify him/her about your participation in this study. We may contact your primary care provider if we have a concern about your health or safety. Please provide your primary care provider's name and contact information below so we may do so.

Doctor's Name _____

Doctor's Phone Number_____

Doctor's Address _____
_____

_____ _____
Your Signature Date