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

V1_08/07/2019