

Name: _____

Date Completed

__/__/__

Study Name: Health Coaching for Chronic Multi-symptom Illness

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.

Doctor's Name _____

Doctor's Phone Number _____

Doctor's Address _____

Your Signature

Date