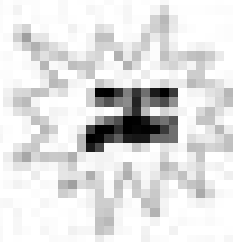




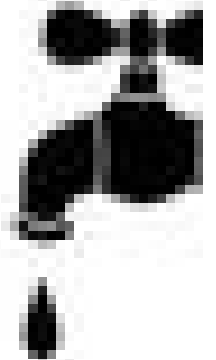
Department of Health and Human Services



Centers for Disease Control and Prevention

Division of Field Epidemiology
Surveillance and Control
Branch

Atlanta, Georgia



Name: _____
Title: _____

Send this questionnaire to:
Dr. [Name], [Address], [City], [State], [Zip]

Blank lines for handwritten responses.

Use the following information to
complete this questionnaire. Indicate
whether or not you have
received this questionnaire in
the past 12 months.

Response
Blank lines for handwritten responses.