

**Attachment 3: Respondent Data Collection Sheet**

Form Approved  
OMB No. 0920-0222  
Exp. Date: 08/31/2021

Notice - CDC estimates the average public reporting burden for this collection of information as 5 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0222).

Assurance of confidentiality - We take your privacy very seriously. All information that relates to or describes identifiable characteristics of individuals, a practice, or an establishment will be used only for statistical purposes. NCHS staff, contractors, and agents will not disclose or release responses in identifiable form without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 U.S.C. 242m(d)) and the Confidential Information Protection and Statistical Efficiency Act of 2002 (CIPSEA, Title 5 of Public Law 107-347).



**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Public Health Service  
Centers for Disease Control and Prevention

National Center for Health Statistics  
3311 Toledo Road  
Hyattsville, Maryland 20782

**Respondent Data Collection Sheet**

**This form asks for basic information about you. At the end of the study, your information will be combined with information from other people in the study and will help us form a picture of the characteristics the people who participated in our study. For our records we would appreciate it if you would take a minute to fill out this form.**

**1. If you have one, what is your sub-specialty?**

\_\_\_\_\_

**2. How long have you been practicing medicine?**

\_\_\_\_\_

**3. Do you staff an obesity clinic?**

Yes, full time      Yes, part time      No

**4. What is your gender?**

Male      Female      Other \_\_\_\_\_

**5. Are you Hispanic or Latino?**

Yes      No

**6. What is your race? Mark one or more races to indicate what you consider yourself to be.**

American Indian or Alaska Native  
Asian  
Black or African American  
Native Hawaiian or other Pacific Islander  
White