

Expanding PrEP in Communities of Color (EPICC+)

**Attachment 4b
Aim 1 Provider Training Contact Information**

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

Provider Contact Information CRF

Instructions: Complete this form for all provider participants immediately after they are consented.

- Participant study ID: _____
 - Participant code: _____
 - Date of CRF completion: _____ (mm/dd/yyyy)
 - Time of CRF completion: _____ (hh:mm)
 - Name of study staff completing CRF: _____ (first and last name)
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1. Provider's first name: _____
 2. Provider's last name: _____
 3. Provider's email address: _____
 4. Providers phone number: _____
 5. Is it okay to leave voicemails at the provided phone number?
 - ☐ Yes
 - ☐ No
 6. What is your preferred method of communication?
 - ☐ Phone calls
 - ☐ Emails