**REPSONSE**

**[Healthcare Professional's Name]**

[Healthcare Professional's Department]

[Healthcare Organization's Address]

[City, State, ZIP Code]

To give you a better understanding of the study and its contents, we kindly ask you to make an appointment.. We assume that this appointment will take 1 - 1.5 hours.

For scheduling purposes, we ask you to suggest dates within the next 4 weeks from the following times. If possible, we will reserve an appointment for you. Otherwise we will contact you by telephone.

|  |
| --- |
| Yes, I would like to be informed about participation in EUthyroid2 and make an appointment. |
| Suggested date | \_ \_. \_ \_. 2024 | ☐08:00 AM | ☐09:00 AM | ☐10:00 AM | ☐10:00 AM |
| Suggested date | \_ \_. \_ \_. 2024 | ☐ 12:00 PM | ☐ 13:00 PM | ☐ 14:00 PM | ☐ 15:00 PM |
| Suggested date | \_ \_. \_ \_. 2024 | ☐08:00 AM | ☐09:00 AM | ☐10:00 AM | ☐10:00 AM |
| Suggested date | \_ \_. \_ \_. 2024 | ☐ 12:00 PM | ☐ 13:00 PM | ☐ 14:00 PM | ☐ 15:00 PM |
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| Suggested date | \_ \_. \_ \_. 2024 | ☐ 12:00 PM | ☐ 13:00 PM | ☐ 14:00 PM | ☐ 15:00 PM |

Please provide us with a telephone number and/or e-mail address where we can reach you if your desired appointment is no longer available.

**You can reach me at:**

**Telephone:**

**E-Mail:**

**Date, Signature:**