**Fibromyalgia Network Support Group Questionnaire**

If you would like to be added to our referral network, please complete this form and return it to Fibromyalgia Network, PO Box 31750, Tucson, AZ 85751-1750, or fax to (520) 290-5550.

**Your Name:** ___________________________ **Date:** ___________________________

**Support Group Name:** ______________________________________________________

**Address:** __________________________________________________________________

**City:** ___________________________ **State:** ___________ **Zip:** ___________

**Phone:** (_____ ) __________________ **E-mail:** ___________________________

**Fax:** (_____ ) __________________**** **Website:** __________________________

☐ Check here to have e-mail / Website listed on referral sheet

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Are you taking over an existing group? ☐ Yes ☐ No, I am starting a new group.

If yes, who was the previous leader: __________________________________________

Is there a fee or suggested donation to attend your support group? ☐ Yes ☐ No

If yes, please indicate amount: $ __________ per ___________________________

My support group is affiliated with: ☐ Arthritis Foundation  ☐ Hospital

☐ CFIDS Association  ☐ Non-profit organization: __________________________

☐ Clinic  ☐ None of the above

How often are group meetings? _____________  Average number of people at meetings? _____________

Does your support group mail or distribute any published materials? ☐ Yes ☐ No

If yes, please indicate what types of materials: __________________________________

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By signing this form, I give the Fibromyalgia Network permission to add my name, address, and phone number to their referral network. In addition, I acknowledge that referrals are added and removed at the discretion of Fibromyalgia Network. I believe that FMS and CFS fall into the same family of syndromes and I am eager to assist people with either diagnosis.*

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**Signature** ___________________________ **Date** ___________________________

*The Fibromyalgia Network serves both FMS and CFS diagnosed patients, therefore, we cannot predict which diagnoses they will have when we refer them to you.

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For office use only:  Date received: ___________ Date added: ________ Date removed: ___________

**Notes:**