



Date: \_\_\_\_\_

### Wisconsin Tobacco Quit Line PROVIDER INQUIRY FORM

Name: \_\_\_\_\_ Organization: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

In order to provide the best possible service to patients and healthcare providers, the Wisconsin Tobacco Quit Line wants to know about and correct any problems with our services as soon as possible. Please complete the form below as accurately as you can so we can investigate and resolve the problem. We will address your concern within seven days of receipt. The Quit Line Coordinator will contact you within two weeks of receiving this form to update you on the progress and findings. Thank you for bringing this to our attention.

**CALLER INFORMATION:**

Caller's First Name: \_\_\_\_\_ County of Residence: \_\_\_\_\_

Approximate Date of Call/Fax: \_\_\_\_\_

Please provide detailed information below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please fax completed form to Robin Perry, Quit Line Coordinator, at 608-265-3102.  
Or e-mail it to [quitline@ctri.medicine.wisc.edu](mailto:quitline@ctri.medicine.wisc.edu).

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For Quit Line use only:

Date Received:

Follow-up Plan:

Results: