

Thank you very much for your consent to participate in The Metastatic Breast Cancer Project. To proceed with our study, we have asked you for information about:

1. Your contact information, including your current mailing address, so that we can send you a saliva kit
2. The name and contact information for the physician(s) who has/have cared for you throughout your experiences with breast cancer, so we can obtain copies of your medical records
3. The names of the hospitals / institutions where you've had biopsies and surgeries, so we can obtain some of your stored tumor samples

Printed below is the information you have provided to us:

**YOUR CONTACT INFORMATION:**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_