

First three letters of patient's last name:

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ILL CONTACTS - DETAILS

Name 3	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Name 4	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Name 5	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Name 6	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Name 7	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Name 8	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Name 9	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Name 10	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk