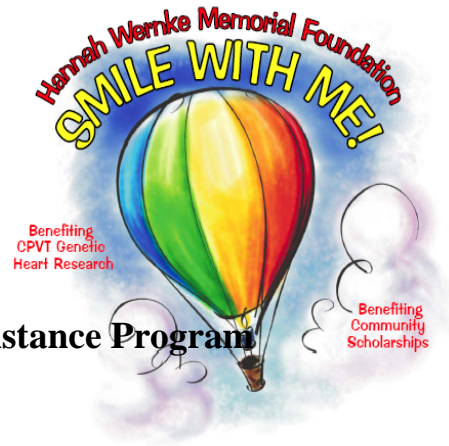


Hannah Wernke Memorial Foundation
P.O. Box 361221
Strongsville, Ohio 44136
HannahWernkeMemorialFoundation.com



Hannah Wernke Memorial Foundation Patient Assistance Program
*** Program Participation Survey ***

1) What is the name of the patient that we were able to assist in receiving the FAMILION CPVT Test? Did the test results come back positive or negative?

_____ positive negative (circle one)

2) What impact have the test results had on you and your family?

3) As you sought to better understand CPVT, what types of resources did you find helpful?

- a. Internet websites (which ones?) _____
- b. Newspaper articles (which ones?) _____
- c. Books (which ones?) _____
- d. Other _____

4) Did you feel that your (or your child's) physician was a good resource when trying to learn more about the diagnosis of CPVT? ___yes ___no

5) Are you aware of any patient advocacy groups that provide information on CPVT? ___yes ___no

If yes, please list: _____

6) Would you be willing to allow the Hannah Wernke Memorial Foundation to reach out to you to discuss your story and how our assistance was able to help your family? Our goal, if you are comfortable, would be to share your story with those who provided funding for this patient assistance program so that they may be touched by the benefits they have provided. ___yes ___no

If yes, please provide us with your contact information (telephone and/or email address as well as the best time to reach you)

Home phone: _____

Email address: _____

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