Reference Code: _____

1) Date of Request (mm/dd/yyyy): ____ /___ /_____

Privacy Notice: *All information collected through this form shall be used for the purpose of (1) database of TB care facilities of the National TB Control Program (NTP) (2) basis for processing of ITIS account, and (3) contacting for patient referrals and informing of NTP activities. The facility details will be accessible by the public through the NTP website. If you wish to revoke your registration, you may send us an email via ntp.helpdesk@doh.gov.ph.*

2) Name of Contact Person: _____
Last Name First Name Middle Name

3) Office:

4) Address:

5) Landline: | 6) Fax No. | 7) Mobile No.

8) **DESCRIPTION OF REQUEST**: *(Please clearly write down the details of the request.)*

REQUEST FOR FACILITY ADDITION

*Complete Name of Facility:	
*Complete Address:	Street: _____ Barangay: _____ Municipality: _____ Province: _____ Region: _____
*Contact Number:	
*E-mail Address:	
Number of Workers:	

*Facility Type:

[ ] Clinic
[ ] Hospital
Level: [ ] Infirmary [ ] Primary [ ] Secondary [ ] Tertiary
[ ] RHU/Health Center
[ ] Jail
[ ] Prison
[ ] Laboratory
Indicate if: [ ] NTP Laboratory Network [ ] Laboratory Consortium [ ] Both
[ ] QA Center
[ ] Warehouse
[ ] Office/Organization/Project

*Engager: *For Clinic and Hospital*

[ ] Local Government Unit (LGU)
[ ] Center for Health Development (CHD)
[ ] Philippine Coalition Against TB (PhilCAT)
[ ] Culion Foundation, Inc. (CFI)
[ ] Philippine Business for Social Progress (PBSP)
[ ] Family Health International 360 (fhi360)
[ ] University Research Company (URC)
[ ] Innovations for Community Health (ICH)
[ ] Medical Societies
[ ] Others _____

*Ownership:	[ ] Public [ ] Private
*HIV Category: *For Clinic/Hospital/RHU/Health Center/Jail/Prison*	[ ] N/A [ ] A [ ] B [ ] C

*Services Provided:

For Clinic/Hospital/RHU/Health Center/Jail/Prison
[ ] Notifying (MTBN)
[ ] DOTS
If DOTS: [ ] Providing [ ] Referring
[ ] iDOTS
[ ] PMDT
If PMDT: [ ] TC [ ] STC

For Laboratory (check all applicable services)
[ ] Xpert MTB/Rif [ ] Xpert MTB/Rif Ultra [ ] Xpert MTB/XDR
[ ] Truenat MTB Plus [ ] Truenat MTB-RIF
[ ] Smear Microscopy [ ] TB Lamp
[ ] TB Culture
[ ] LPA
[ ] DST
[ ] Xray

*Date Start Operational: *(If specific date is not known, indicate Jan 1 of year known)*	
*Business Hours *(Day and Time):*	

**means required field*

9) **APPROVED BY:** _____ _____
Name & Signature of Head of Office Date Signed

_____
Position

(For Knowledge Management and Information Technology Service only)

10) Date Received (mm/dd/yyyy): ____/____/_____ 11) Time Received (hh:mm) ____:____ AM PM

12) **ACTIONS TAKEN:** *(Use separate sheet if necessary)*

DATE (a)	TIME (b)	ACTION TAKEN (c)	ACTION OFFICER (d)	SIGNATURE (e)

13. NOTED BY:	14.	15.
Name and Signature of Supervisor	Position	Date Signed