

	Knowledge Management and Information Technology Service	Page No.	Page 1 of 1
		Revision No.	0
	Service Request Form		Effectivity:

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:

<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital *Level: <input type="checkbox"/> Infirmary <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> RHU/Health Center <input type="checkbox"/> Jail <input type="checkbox"/> Prison	<input type="checkbox"/> Laboratory *Indicate if: <input type="checkbox"/> NTP Laboratory Network <input type="checkbox"/> Laboratory Consortium <input type="checkbox"/> Both <input type="checkbox"/> QA Center <input type="checkbox"/> Warehouse <input type="checkbox"/> Office/Organization/Project
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*Engager: *For Clinic and Hospital*

<input type="checkbox"/> Regional Health Office <input type="checkbox"/> Local Government Unit <input type="checkbox"/> PhilCAT <input type="checkbox"/> PTSI <input type="checkbox"/> fhi360	<input type="checkbox"/> PBSP <input type="checkbox"/> URC <input type="checkbox"/> Kalinga Health <input type="checkbox"/> Medical Societies <input type="checkbox"/> Others _____
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*Services Provided:

<i>For Clinic/Hospital/RHU/Health Center/Jail/Prison</i> <input type="checkbox"/> Notifying (MTBN) <input type="checkbox"/> DOTS <i>If DOTS:</i> <input type="checkbox"/> Providing <input type="checkbox"/> Referring <input type="checkbox"/> iDOTS <input type="checkbox"/> PMDT <i>If PMDT:</i> <input type="checkbox"/> TC <input type="checkbox"/> STC	<i>For Laboratory</i> <input type="checkbox"/> Smear Microscopy <input type="checkbox"/> TB Lamp <input type="checkbox"/> Xpert MTB/Rif <input type="checkbox"/> TB Culture <input type="checkbox"/> LPA <input type="checkbox"/> DST <input type="checkbox"/> Xray
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*Ownership: ☐ Public ☐ Private

*HIV Category: *For Clinic/Hospital/RHU/Health Center/Jail/Prison* ☐ N/A ☐ A ☐ B ☐ C

*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