

To be filled upon completion of required wholesite orientation sessions

Tool T-02B



FAMILY PLANNING WHOLE SITE PARTICIPANT REGISTRATION

Date Attended : ___/___/___ (dd/mm/yy)

First name: _____

National ID: _____

Gender:

Middle name: _____

Male

Last name: _____

Female

Birth date: ___/___/___ (day / month / year)

Contact information: Cell phone: _____

Email address: _____

ENTER WORKSTATION INFORMATION:

Name _____

Location: Geography _____ Sub Geography _____

Mailing address: PO Box _____ Post Code _____ Town/City _____

Work contact (if available): Phone _____

Tick your cadre / area of work at this facility from the list below

Health Sector only, select one from list:

- | | | |
|-----------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Public Health - PHO, PHT, etc | <input type="checkbox"/> Administration |
| <input type="checkbox"/> Clinical Officer | <input type="checkbox"/> Counselor - all types | <input type="checkbox"/> Security |
| <input type="checkbox"/> Nurse- all registered & enrolled | <input type="checkbox"/> Pharmacy - PharmTech, etc | <input type="checkbox"/> All other support staff |
| <input type="checkbox"/> Nurse- BScn and above | <input type="checkbox"/> Nutritionist - all types | |
| <input type="checkbox"/> Laboratory - LabTech, etc | <input type="checkbox"/> Health records - Statistican, MRIO, clerk | |
| <input type="checkbox"/> Other, specify _____ | | |

Signature _____

To be filled upon completion of required wholesite orientation sessions

Tool T-02B

FP WHOLESITE PARTICIPANT REGISTRATION FORM

Date Attended : ___/___/___ (dd/mm/yy)

First name: _____

National ID: _____

Gender:

Middle name: _____

Male

Last name: _____

Female

Birth date: ___/___/___ (day / month / year)

Contact information: Cell phone: _____

Email address: _____

ENTER WORKSTATION INFORMATION:

Name _____

Location: Geography _____ Sub geography _____

Mailing address: PO Box _____ Post Code _____ Town/City _____

Work contact (if available): Phone _____ Fax _____

Tick your cadre / area of work at this facility from the list below

Health Sector only, select one from list:

- | | | |
|-----------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Public Health - PHO, PHT, etc | <input type="checkbox"/> Administration |
| <input type="checkbox"/> Clinical Officer | <input type="checkbox"/> Counselor | <input type="checkbox"/> Security |
| <input type="checkbox"/> Nurse- all registered & enrolled | <input type="checkbox"/> Pharmacy - PharmTech, etc | <input type="checkbox"/> Support staff |
| <input type="checkbox"/> Nurse- BScn and above | <input type="checkbox"/> Nutritionist | |
| <input type="checkbox"/> Laboratory - LabTech, etc | <input type="checkbox"/> Health records - Statistican, MRIO, clerk | |

Other, specify _____

Signature _____