**National Malaria Elimination Program**
Malaria Quality Assurance & Quality Control

MQC: FORM 1a
DETAILS OF SLIDES SENT FOR VALIDATION (CROSS-CHECKING)
(स्लाईड पठाउँदा बिरामीको विवरण सहितको भर्नुपर्ने फाराम)

Month: _____ Year: _____ Province: _____ District: _____

Health Facility Name: _____

Type: Provincial Hospital ☐ District Hospital ☐ PHC ☐ Designated Centers ☐ Health Post ☐ Private Hospital ☐

Other (Specify): ☐ _____

| S. N. | Slide No. | Name of the Patient | Age | Sex | Palika | Ward No. | Village/ Tole | Contact No. | Remarks |
|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| 4. | | | | | | | | | |
| 5. | | | | | | | | | |
| 6. | | | | | | | | | |
| 7. | | | | | | | | | |
| 8. | | | | | | | | | |
| 9. | | | | | | | | | |
| 10. | | | | | | | | | |
| 11. | | | | | | | | | |
| 12. | | | | | | | | | |
| 13. | | | | | | | | | |
| 14. | | | | | | | | | |
| 15. | | | | | | | | | |
| 16. | | | | | | | | | |
| 17. | | | | | | | | | |
| 18. | | | | | | | | | |
| 19. | | | | | | | | | |
| 20. | | | | | | | | | |

Examined by (LT/LA)

Name: _____

Signature: _____

Noted by

Name: _____

Signature: _____

Head of the Facility

Name: _____

Signature: _____

Date of Submission: _____