



**NATIONAL EXTERNAL QUALITY ASSESSMENT SCHEME (SEROLOGY)
2013 Registration Form**

Check if () New Participant () Old Participant, indicate Laboratory Code: _____

A. LABORATORY INFORMATION (Write legibly in bold letters, no abbreviations)

Name of Clinical Laboratory: _____

Address: _____

Zip Code: _____ Region: _____

Contact Person(Laboratory) to whom test material is to be dispatched: _____

Position: _____ Email of laboratory/ contact person (mandatory): _____

Lab Tel. No: _____ Lab Fax No: _____ Mobile No. of contact person: _____

Type of Testing Site: (check all items that apply)
Private: () Hospital Diagnostic lab () Hospital Blood Screening Center () Clinic () OFW () Diagnostic laboratory
Government: () Hospital Diagnostic lab () Hospital Blood Screening Center () Clinic : SHC, CHO, RHU

B. LABORATORY PERSONNEL

Name of Pathologist:	Mobile No: Email (mandatory):
Name of Chief Med Tech/QA Officer:	Mobile No: Email (mandatory):
Name of HIV Proficient Med Tech: Proficiency Cert No: Assigned Section: () Diagnostic () Blood Bank Service () Both (use separate sheet if more than one proficient med tech in your institution)	Mobile No: Email (mandatory):

C. AVAILABLE SEROLOGIC TEST (please check box)

Check box which tests does your laboratory wants to participate in	Method	Name/Brand of kit used (mandatory)
() anti-HIV	() Rapid () EIA	Anti-HIV :
() anti-HCV	() Rapid () EIA	Anti-HCV:
() HBsAg	() Rapid () EIA	HBsAg:

D. Annual CENSUS:

Test Done	Total Number of test done (2012)	Total Number –Reactive (Screening test)	Total Number- Positive (Confirmatory test)
Anti-HIV			
Anti-HCV			
HBsAg			
Syphilis			

E. Is there an available courier service near your area? (mandatory)

() YES , name of Courier service(s) _____
() NO, if none, indicate another address(with available courier service) and contact person where your EQAs panels can be sent _____

F. What is your laboratory's performance rating in the previous EQAS (2012)

HIV ()Excellent ()Satisfactory ()Unsatisfactory
HBV ()Excellent ()Satisfactory ()Unsatisfactory
HCV ()Excellent ()Satisfactory ()Unsatisfactory

If your rating is Satisfactory/Unsatisfactory, fill-up and submit corrective action form.

This laboratory agrees to abide by the rules of participation of the External Quality Assessment Scheme

Conformed by: (Head of Agency or Pathologist or Chief Medical Technologist)

Name/Signature: _____

Position: _____ Date: _____

CORRECTIVE ACTION FORM

Name of Laboratory: _____

Lab Code: _____

Error: _____

Action/s Taken to Identify Source of Error:

Action/s Taken to Correct Error:

Comments:

Name/Signature of Medical Technologist Date _____

Name/Signature of Supervisor/Pathologist Date _____