FACILITY (Dept./ Hosp./ Institution/ JKN/ Division/ Program)					
KPI: (Please ☑ the option) ☐ **CLINICAL SERVICE** ☐ **HPIA** ☐ **PPTPA:** Name : Designation :					
PERIOD OF PERFORMANCE: (Please ☑ the option) ☐ **JAN – MAR** ☐ **APR – JUN** ☐ **JUL – SEPT** ☐ **OCT– DEC** ☐ **JAN – JUN** ☐ **JUL – DEC** ☐ **JAN – DEC** ☐ **OTHERS:** Please specify:					**YEAR:**
INDICATOR				**STANDARD**	
NUMERATOR		**DENOMINATOR**		**PERFORMANCE ACHIEVED**	
SIQ ☐ **Yes** ☐ **No** **IF Yes, SIQ FORM SUBMITTED** ☐ **Yes** ☐ **No** ☐ **In progress**					

NOTE: This form needs to be filled by the Officer in charge of the indicator at the facility.

PERFORMANCE VERIFICATION:

Person in charge of the indicator	**Head of Unit/ Department/ Section/ Deputy Director**
(Name/ Signature/ Designation/ Stamp) Date: Contact Number:	(Name/ Signature/ Designation/ Stamp) Date:
Hospital Director/ State Director/ Division Director/ Head of Program (Name/ Signature/ Designation/ Stamp) Date:	

FOR THE USE OF QUALITY/ KPI UNIT ONLY

PERFORMANCE CONFIRMATION:

☐ The above performance data is verified by the appropriate officers.

☐ Others (Please specify: ……)

Person in charge
(Name/ Signature/ Designation/ Stamp) Date: