health
Department:
Health
REPUBLIC OF SOUTH AFRICA

VMMC Surgical Register Receipt Form

Submitting Partner Org. (or GP) and Prime Partner:	Write name of implementing partner or GP	Write name of prime partner (or list as N/A)
Facility and District of Submission (Names):	Write name of DHIS-reporting facility	Write name of the district
Origin of Data (Mobile Unit/VMMC Camp etc.):	Write where the VMMCs were conducted and the name of the originating facility (if available)	
Number of VMMCs Submitted (Count from Registers):	Write the number of VMMCs to be submitted into the DHIS	
Date Submitted to the DoH Facility:	Write the date submitted	

Print Name of Submitting (Partner/GP) Official_____

Signature of Submitting (Partner/GP) Official_____

Contact Information (Email/Phone No.)_____

☐ ***Check box (✓) once a routine quality review of yellow VMMC register tear-off sheets has been conducted and the forms have been submitted to the DoH official listed below***

Print Name of Receiving (DoH) Official_____

Signature of Receiving (DoH) Official_____

Contact Information (Email/Phone No.)_____

***A checked box & DoH signature above ensures that the yellow VMMC register tear-off sheets have been reviewed & are ready for submission into DHIS by the above DoH official**