GOVERNMENT OF THE DISTRICT OF COLUMBIA

Administration for HIV Policy and Programs
OraQuick Advance Quarterly Progress Report

Instructions: To request OraQuick Advance tests please submit this report upon initial order and on a quarterly basis, thereafter. Please provide DOH/AHPP with the information/documentation identified below.

1. Program Manager Contact Information:

Name _____
Title _____
Organization _____
Address _____
Address _____
City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____

I attest by my signature that all of the information provided is correct and accurate.

Signature: _____

Date: _____

2. OraQuick Advance Test Kit Order:

Please provide us with the estimated number of OraQuick Advance devices you will need to cover a three-month period.

NUMBER OF KITS REQUESTED
_____

Have your ordered tests kits through the testing distribution program before?
No ____ Yes ____ If Yes, last order date _____quantity _____

3. HIV Prevention Funding Sources:

Have you been funded by the following agencies to perform HIV testing and/or prevention projects? Please circle all that apply.

CDC AHPP SAMHSA HRSA DOH OTHER_____

4. CLIA Certificate of Waiver CLIA Lab Certification Number:

CLIA certificate expiration date: __/__/____

Please provide a copy of your CLIA certificate of waiver or CLIA lab certification number via fax to Yasir Shah at (202) 671-4860.

5. Quality Assurance/Quality Control Plan:

Please provide a copy of your quality assurance plan for testing sites to Yasir Shah by fax to (202)-671-4860 or e-mail the document to yasir.shah@dc.gov. In the subject line please write: "[Organization Name]: Quality Assurance Plan". Once your quality assurance plan has been approved by DOH/AHPP, you will be notified via email and will not be required to re-submit this information quarterly. If changes to your quality assurance plan are necessary, you will be contacted via email in regards to required changes and must submit a modified plan with your next progress report.

6. Training on HIV rapid testing:

Please provide the number of persons who will administer the rapid tests, the dates these individuals were trained, and method of training (by DOH/AHPP or OraSure). If there are changes to the list quarterly, please update the information as needed. *Please note that DOH/AHPP and/or OraSure provide monthly rapid test training. If additional training is needed please contact Cynthia Green at cynthia.green@dc.gov.*

Tester Name	Date of Training	Training Provided By

Comments:_____

_____

_____

FOR OFFICIAL DOH USE ONLY:					
RECEIVED DATE:	Initial:	**DATE ORDER FILLED:**	Initial	**DATE ORDER SHIPPED**	Initial