PERFORMANCE VERIFICATION FORM | PVF.CPSU Ver. 2022

FACILITY (Dept./ Hosp./ Institution/ JKN/ Division/ Program)	

KPI: (Please ☑ the option)
☐ **CLINICAL SERVICE** ☐ **HPIA** ☐ **PPTPA:** Name　　　　　:
　　　　　　　　　　　　　　　　　　　　　　Designation :

PERIOD OF PERFORMANCE: (Please ☑ the option)	**YEAR:**
☐ JAN – MAR　☐ APR – JUN　☐ JUL – SEPT　☐ OCT– DEC ☐ JAN – JUN　☐ JUL – DEC　☐ JAN – DEC　☐ OTHERS: Please specify:	☐☐☐☐

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: