UGANDA AIDS INDICATOR SURVEY
FIELD TEST RESULTS FORM
ADULTS AGE 15-59 YRS

IDENTIFICATION

CLUSTER NUMBER . . . . . [ ][ ][ ]

HOUSEHOLD NUMBER . . . . . [ ][ ]

RESPONDENT LINE NUMBER . . . . . [ ][ ]

NAME OF SURVEY RESPONDENT _____ .

SEX (MALE=1; FEMALE=2) . . . . . [ ]

AGE . . . . . [ ][ ]

BAR CODE LABEL . . . . . *Paste bar code label here*

FIELD TEST VISITS

	1	2	3	FINAL VISIT
DATE				DAY . . . . . [ ][ ]
				MONTH . . . . . [ ][ ]
				YEAR . . . . . 2 0 1 [ ]
LAB TECH NAME				LAB TECH NUMBER [ ][ ][ ]
RESULT*				RESULT [ ]
NEXT VISIT: DATE				
TIME				TOTAL NUMBER OF VISITS [ ]

*RESULT CODES:

1 TESTED
2 NOT AT HOME _____ (SPECIFY)
3 POSTPONED
4 REFUSED
5 INCAPACITATED
6 OTHER _____ (SPECIFY)

TEAM SUPERVISOR

NAME _____

DATE _____ [ ][ ][ ]

1. REQUEST FOR CONSENT TO TESTING

THE LABORATORY TECHNICIAN WILL BE RESPOONSIBLE FOR OBTAINING INFORMED CONSENT FOR THE TESTING.

101	CHECK AGE ON COVER PAGE 15-17 YEARS OLD ↓ ☐ 18-59 YEARS ☐ ↓ (SKIP TO 103)		
101A	IS [NAME] EMANCIPATED (I.E., MARRIED OR LIVING WITHOUT SUPERVISION) OR NON-EMANCIPATED (I.E., LIVING UNDER CARE OF PARENT OR OTHER ADULT)?	EMANCIPATED . . . . . 1 NON-EMANCIPATED 2	→103
102	FOR NONEMANCIPATED YOUTH AGE 15-17 YEARS, IDENTIFY PARENT OR OTHER ADULT RESPONSIBLE FOR THE YOUTH. REQUEST CONSENT FROM THE PARENT OR OTHER ADULT RESPONSIBLE FOR YOUTH FOR THE TESTING BEFORE ASKING THE YOUTH THEMSELVES TO CONSENT.		
103	HIV is one of the leading causes of death in this country. Syphilis is also a common sexually transmitted disease. Both HIV and syphilis can be found in your blood. We want to see how many people in Uganda have syphilis and HIV. We would also like to store some of the blood that remains and test for other diseases in the future. Your household has been selected purely by chance from your community. As part of this survey we also ask participants to give us a little blood. We will be asking 37,000 people from all over the country to give us some blood. You can choose to give blood or not. It is your choice. If you choose not to give blood, there is no problem. If you agree, we would like to draw a little blood. We need about a spoonful of blood from a vein in your arm. We will fill the blood into three small tubes. We would prefer to have venous blood for purposes of our study. However, if you don't want blood taken from your vein, we can take a little blood from your finger. We use only new sterile needles to collect blood. The tests are simple, fast and accurate. We can do them here in the home. They take about 30 minutes. We can tell you the results right away. For HIV, we will offer to counsel you before and after the test. That way you know what the test and the result means. If you test positive for syphilis, we will offer you treatment at home free of charge, using penicillin. If you are allergic to penicillin, we will offer you another medication. For people who test HIV-positive, we will use one of the other blood tubes to do another test. This test cannot be done in the home .We need to do it at a laboratory. The testing is to see how many CD4 cells the person with AIDS has. These cells help a person to stay healthy. We will send the blood for this test to a laboratory in Entebbe. We will give each person who tests HIV positive a unique code with which they can get the result of their CD4 test in a health facility nearby [MENTION NAMES]. The health providers there will advise the person on the need for treatment. The result will be ready in about 6 weeks. The results will remain available in the health facility for 6 months. If the result is not picked in that period, the person who tests HIV positive will have to have the tests again in a health facility providing their services. If you agree, we will keep the leftover blood. We may use it for later testing related to health or diseases in a central laboratory. Because we do not keep your name, we cannot tell you about any results from future testing. Such testing will help the Government to improve health in Uganda. You can join this study even if you don't want us to keep your blood. You can decide to give blood for the tests or not to give blood. You can decide if you want all, only some or none of the tests will be done in the home. You can also decide for each test if you want the results given to you. You may get some bruising where the blood is taken from. If you get any discomfort, bleeding or swelling at the site, please contact our study staff or your health worker. All information you share will be kept secret. We will put a study number, not your name, on the blood tubes. That way we can make sure nobody can tell to whom the blood belongs. 1. Your name or identifiable information will NOT be used in any survey materials. 2. Only research team members will have access to your data and specimens. 3. Skilled interviewers will be trained to protect your privacy. We do not expect major risks from participating in this survey. You may not benefit directly from being part of this survey. As mentioned earlier, we will offer free treatment or advise you what to do. We will provide counseling and results for HIV and syphilis to all who request for them in the household. We will also provide treatment for syphilis for those who are syphilis positive in the household. We shall refer participants who are HIV positive to health facilities for CD4 results as well as for medical care services. We do not offer money for participating in this study. Everything we talk about will be kept secret to the extent allowed by the law. Your test results will be kept secret to the extent allowed by the law. To protect your privacy, we will use a code number to identify you and all specimens. We will keep these records and specimens locked. Only special staff will be able to look at the records or use the specimens. Your name or any other facts that might point to you will not appear when we present this survey or publish its results. We would like to answer all your questions. If you have any questions now, please ask us. If you have any questions in the future, there are other persons that you can contact.Ministry of Health: Dr. Alex Opio: 0414-256683 Dr. Joshua Musinguzi: 0414-256683 Dr. Wilford Kirungi: 0414-256683 If you have any concerns about your rights in this survey, please contact Mr. Tom Lutalo Chairman UVRI Science and Ethics Committee 0414-320272.		

104	REQUEST CONSENT TO TAKE A BLOOD SAMPLE. NONEMANCIPATED YOUTH SHOULD BE ASKED FOR CONSENT ONLY IF THE PARENT OR ADULT RESPONSIBLE FOR YOUTH HAS GIVEN PERMISSION OR CONSENTED.			
	FOR NONEMANCIPATED YOUTH		**SURVEY RESPONDENTS**	
	ASK AND RECORD CONSENT OF PARENT OR OTHER ADULT RESPONSIBLE FOR YOUTH.		ASK AND RECORD CONSENT FROM ALL SURVEY RESPONDENTS EXCEPT NONEMANCIPATED YOUTH FOR WHOM THE PARENT OR OTHER ADULT RESPONSIBLE FOR THE YOUTH REFUSED CONSENT.	
105	Do you agree to have a sample of (NAME'S) blood taken for these tests?	AGREED . . . . . 1 REFUSED . . . . . 2 (RECORD ON COVER AND **END**) (SIGN)	Do you agree to have a sample of blood taken for these tests?	AGREE . . . . . 1 REFUSE . . . . . 2 (RECORD ON COVER AND **END**) (SIGN)
106	IF CONSENT GRANTED, GO ON TO ASK CONSENT SEPARATELY FOR THE SYPHILIS AND HIV TESTS. IF REFUSED, GO TO NEXT ELIGIBLE PERSON IN HOUSEHOLD. IF NO MORE ELIGIBLE PERSONS, GO TO NEXT HOUSEHOLD.			
	NONEMANCIPATED YOUTH		**SURVEY RESPONDENTS**	
	ASK AND RECORD CONSENT OF PARENT OR OTHER ADULT RESPONSIBLE FOR YOUTH.		ASK AND RECORD CONSENT FROM ALL SURVEY RESPONDENTS EXCEPT NONEMANCIPATED YOUTH FOR WHOM THE PARENT OR OTHER ADULT RESPONSIBLE FOR THE YOUTH REFUSED CONSENT.	
107	**SYPHILIS**			
	Do you agree for (NAME'S) blood to be tested for **syphilis**?	AGREED . . . . . 1 → REFUSED . . . . . 2 (SIGN)	Do you agree to have your blood tested for **syphilis** and the results given to you?	AGREED, WANTS RESULT. . . 1 AGREED, DOES NOT WANT RESULT . . . . . 2 REFUSED . . . . . 3 (SIGN)
108	**HIV**			
	Do you agree for (NAME'S) blood to be tested for **HIV**?	AGREED . . . . . 1 → REFUSED . . . . . 2 (SIGN)	Do you agree to have your blood tested for **HIV** and the results given to you?	AGREED, WANTS RESULT. . . 1 AGREED, DOES NOT WANT RESULT . . . . . 2 REFUSED . . . . . 3 (SIGN)
109	**STORED BLOOD**			
	May we store and use any blood from (NAME) that remains for future testing at the central laboratory?	AGREED . . . . . 1 → REFUSED . . . . . 2 (SIGN)	May we store and use any blood that remains for future testing at the central laboratory?	AGREED . . . . . 1 REFUSED . . . . . 2 (SIGN)
110	CHECK 107, 108 AND 109. INDICATE IF RESPONDENT AGREED TO SYPHILIS TEST OR HIV TEST OR TO STORAGE OF BLOOD. AGREED TO SYPHILIS OR HIV TEST OR TO STORAGE OF BLOOD ☐ REFUSED SYPHILIS AND HIV TEST AND STORAGE OF BLOOD ☐ (THANK THE RESPONDENT AND GO TO NEXT PERSON ELIGIBLE FOR TESTING. IF NO MORE ELIGIBLE PERSON, **END** AND GO TO NEXT HOUSEHOLD)			
111	CHECK 108 AND INDICATE IF RESPONDENT AGREED TO HIV TEST AND AGREED TO RECEIVING RESULTS OF HIV TEST AGREED TO HIV TEST AND WANTS HIV TEST RESULTS ☐ DOES NOT WANT HIV RESULTS OR REFUSED HIV TEST (SKIP TO 201) ☐			
112	COUNSELOR SHOULD PERFORM PRE-RESULTS COUNSELING. COUNSELOR SHOULD VERIFY AT THE END OF THE SESSION THAT THE PARTICIPANT WANTS THE HIV TESTS DONE AND WANTS TO BE GIVEN THE RESULTS.			AGREED, WANTS RESULT. . . 1 AGREED, DOES NOT WANT RESULT . . . . . 2 REFUSED . . . . . 3 (SIGN)

2. SPECIMEN COLLECTION AND FIELD TEST RESULT RECORD

201	CHECK THE CONSENT RECORD AND DETERMINE WHETHER OR NOT THE RESPONDENT HAS AGREED TO A SPECIFIC TEST. IF YOU WILL NOT BE CONDUCTING THE TEST AND/OR COLLECTING THE SAMPLE, RECORD REASON IN COLUMN (1) CHECK IF RESPONDENT PREFERS A VENOUS BLOOD DRAW OR FINGER PRICK AND PREPARE ALL OF THE MATERIALS THAT YOU WILL NEED TO COLLECT THE SAMPLES AND TO CONDUCT THE TESTS . ASSIGN A UNIQUE BAR CODE NUMBER TO THE PARTICIPANT. PASTE A LABEL WITH THAT NUMBER ON COVER PAGE. PLACE LABELS WITH THE RESPONDENT'S BAR CODE ON BLOOD TUBES, FILTER PAPER CARD, AND FIELD FORMS. COLLECT SAMPLES AND PERFORM HOME-BASED TESTS FOR WHICH THE RESPONDENT HAS AGREED. RECORD OUTCOME OF THE HOME-BASED TESTS IN COLUMN (2). IF YOU CANNOT CONDUCT OR COLLECT A SAMPLE, RECORD CODE 6 (OTHER) IN COLUMN (1) AND NOTE THE REASON.		
		(1)	(2)
203	**TYPE OF BLOOD COLLECTED** RECORD TYPE OF BLOOD COLLECTED. IF VENOUS, RECORD TUBES OBTAINED. IF NOT OBTAINED, SPECIFY REASON.	VENOUS . . . . . 1 CAPILLARY 2	**EDTA:** YES . . . 1 NO . . . 2 **SST:** YES . . . 1 NO . . . 2 **CD4:** YES . . . 1 NO . . . 2 (SPECIFY)
204	CHECK 107 AND INDICATE IF RESPONDENT AGREED TO SYPHILIS TEST AGREED TO SYPHILIS TEST ☐ → REFUSED SYPHILIS TEST ☐ → (SKIP TO 207)		
205	**SYPHILIS BIOLINE TEST**	TESTED, WANTS RESULT . . . 1 TESTED, DID NOT WANT RESULT . . . . . 2 OTHER _____ 6 (SPECIFY)	**BIOLINE** POSITIVE . . . . . 1 NEGATIVE . . . . . 2 (SKIP TO 207)
206	**SYPHILIS RPR TEST** THIS TEST IS CONDUCTED LATER ONLY FOR PARTICIPANTS WITH A POSITIVE BIOLINE RESULT WHO AGREED TO A VENOUS BLOOD DRAW.	TESTED, WANTS RESULT . . . 1 TESTED, DID NOT WANT RESULT . . . . . 2 REFUSED . . . . . 3 DID NOT PROVIDE VENOUS BLOOD SAMPLE . . . . . 4 OTHER _____ 6 (SPECIFY)	**RPR** REACTIVE . . . . . 1 NONREACTIVE 2
207	CHECK 108 AND INDICATE IF RESPONDENT AGREED TO HIV TEST AGREED TO HIV TEST ☐ → REFUSED HIV TEST ☐ → (SKIP TO 213)		
208	**HIV DETERMINE TEST**	TESTED, WANTS RESULT . . . 1 TESTED, DID NOT WANT RESULT . . . . . 2 OTHER _____ 6 (SPECIFY)	**DETERMINE** POSITIVE . . . . . 1 NEGATIVE 2
209	POSITIVE DETERMINE TEST RESULT ☐ → NEGATIVE DETERMINE TEST ☐ → (SKIP TO 213)		
210	**HIV STATPAK TEST**	TESTED . . . . . 1 OTHER _____ 6 (SPECIFY)	**STATPAK** POSITIVE . . . . . 1 NEGATIVE 2
211	CHECK 210 AND INDICATE STATPAK TEST RESULT NEGATIVE STATPAK RESULT ☐ → POSITIVE STATPAK TEST RESULT ☐ → (SKIP TO 213)		
212	**HIV UNIGOLD TEST**	TESTED . . . . . 1 OTHER _____ 6 (SPECIFY)	**UNIGOLD** POSITIVE . . . . . 1 NEGATIVE 2
213	**DBS ON FILTER PAPER**	COLLECTED . . . . . 1 REFUSED . . . . . 2 OTHER _____ 6 (SPECIFY)	
214	**CD4 TEST** ONLY FOR RESPONDENTS WHO TEST HIV POSITIVE. RECORD AGREEMENT AFTER POST-TEST COUNSELING.	AGREED . . . . . 1 REFUSED . . . . . 2 OTHER _____ 6 (SPECIFY)	

3. SYPHILIS TREATMENT AND REFERRAL RECORD

301	CHECK 205 POSITIVE ☐ NEGATIVE OR OTHER ☐ SKIP TO 401 (INFORM THE RESPONDENT OF NEGATIVE RESULT, OFFER STI BROCHURE, AND ANSWER ANY QUESTIONS).	
302	CHECK 203 AND INDICATE TYPE OF BLOOD COLLECTED. CAPILLARY ☐ VENOUS ☐ (SKIP TO 304)	
303	Your syphilis test result was positive. As I said, the test can only show that you have ever had syphilis. To know if you may have an active case, you must have another test. It is important that you consult a health facility as soon as possible to have that test done. PROVIDE REFERRAL TO HEALTH FACILITY. THEN GO ON TO 401.	
304	Your syphilis test result was positive. As I said, the test can only show that you have ever had syphilis. To know if you may have an active case, we must do another test later today elsewhere using special equipment. For this test, we will use blood from one of the blood tubes you already gave. I [One of my colleagues, who is a nurse] will return tomorrow to give you the result of the test. If the test shows that you may have an active syphilis, we will offer you treatment, either a penicillin injection or antibiotic tablets. RECORD APPOINTMENT TIME _____	
305	RETURN TO THE HOUSEHOLD AFTER THE RPR TEST IS COMPLETE. BEFORE RECORDING THE RESULTS HERE AND IN 206 CHECK THAT THE BAR CODE ON THE COVER MATCHES THE BAR CODE IN THE LABORATORY FORM. REACTIVE ☐ NON-REACTIVE ☐ (INFORM THE RESPONDENT OF THE NEGATIVE RESULT, OFFER STI BROCHURE, ANSWER ANY QUESTIONS, AND GO TO **322** TO OFFER PARTNER REFERRAL)	
306	We have completed the second syphilis test. Your result from this test shows that you may have active syphilis, which can cause serious health problems if it is not treated. The treatment is either a penicillin injection or antibiotic tablets. We can provide you with treatment immediately here. However, if you would prefer, we can provide you a referral to receive treatment at another location in the community today or at a health facility. The decision to be treated or to receive a referral is up to you. Do you want to receive treatment now in the house? **IF NO**: Would you like to meet me (my colleague) at another site to get treatment or would you prefer to go to a health facility for treatment? IF AGREES TO IMMEDIATE TREATMENT, GO TO 307 AND ASK ALL APPROPRIATE SCREENING QUESTIONS BEFORE ADMINISTERING INJECTION OR PROVIDING ANTIBIOTICS. IF PARTICIPANT WANTS TREATMENT IN A LOCATION OTHER THAN THE HOME, DISCUSS THE SITE AND TIME WHERE YOU (A COLLEAGUE) WILL BE AVAILABLE TO PROVIDE TREATMENT. IF TREATMENT IS PROVIDED AT ANOTHER LOCATION, THE TREATMENT SCREENING QUESTIONS MUST BE COMPLETED BEFORE TREATMENT IS PROVIDED. IF WANTS REFERRAL, COMPLETE REFERRAL CARD.	YES, NOW IN HOME . . . . . 1 YES, ANOTHER LOCATION . . . 2 NO, WANTS REFERRAL TO HEALTH FACILITY . . . . . 3 (PROVIDE REFERRAL TO FACILITY FOR RESPONDENT, GO TO 322 TO OFFER PARTNER REFERRAL) DOES NOT WANT TREATMENT/REFERRAL . . . 4 _____ (SIGN) (GO TO 401)
307	**ADVISE RESPONDENT OF POSSIBILITY OF ALLERGIC REACTION TO PENICILLIN INJECTION AND SCREEN FOR PRIOR REACTIONS.** For most people, the treatment is an injection of penicillin. However, in very rare instances, an individual may experience an allergic reaction to a penicillin injection, e.g., an itchy skin rash and/or swelling of the lips, mouth or face. Sometimes, in very rare instances, the person may have shortness of breath or may collapse. If you have not had this type of reaction before, it is unlikely that you will experience it today. However, just to be sure, I need to ask you some questions about your experience with penicillin before I give you the treatment. If you receive an injection, our team will stay in the area about two hours after the injection and you can contact me immediately or any member of my team working in your village/locality for any problem following your injection with penicillin.	
308	To your knowledge, have you ever been given a penicillin injection before?	YES . . . . . 1 NO . . . . . 2 → 310
309	Have you ever had any reaction to penicillin?	YES . . . . . 1 → 315 NO 2
310	Have you had any other type of injection before?	YES . . . . . 1 NO . . . . . 2 → 312
311	Did you have any reaction at any time when you had an injection?	YES . . . . . 1 → 315 NO 2

312	**ASK FOR CONSENT FOR PENICILLIN INJECTION.** I would like to give you a penicillin injection. You will need only one injection. However, if you want, I can give you antibiotic tablets or a referral to a health center where you can consult about the treatment.	
313	May I give you the penicillin injection now?	YES . . . . . 1 NO, PREFERS TABLETS . . . 2 (GO TO 317) NO, PREFERS REFERRAL TO HEALTH FACILITY . . . . . 3 (PROVIDE REFERRAL TO FACILITY FOR RESPONDENT AND GO TO 322 TO OFFER PARTNER REFERRAL). DOES NOT WANT TREATMENT/REFERRAL . . . 4 (SIGN) (GO TO 401)
314	**AFTER GIVING THE PENICILLIN INJECTION** It is very unlikely that you will have a reaction to the penicillin. However, if you experience a reaction that I talked about earlier (that is, itchy skin rash, swollen face, mouth or tongue, or difficulty breathing, you should immediately contact me or any member of our team that is working in this area or go to the nearest health center. WAS THERE ANY REACTION TO PENICILLIN? IF YES, EXPLAIN IN COMMENTS PAGE	YES, REACTION TO PENICILLIN . . . . . 1 (GO TO 322) NO REACTION TO PENICILLIN . . . 2 (GO TO 322)
315	**ASK FOR CONSENT TO GIVE ANTIBIOTIC TABLETS** Since it is possible that you may have a reaction to the injection, I am going to give you antibiotic tablets instead if you agree. If you would prefer, I can instead give you a referral to a health center for treatment.	
316	Would you like me to give you the antibiotic tablets?	YES . . . . . 1 NO, PREFERS REFERRAL TO HEALTH FACILITY . . . . . 2 (PROVIDE REFERRAL TO FACILITY FOR RESPONDENT AND GO TO 322 TO OFFER PARTNER REFERRAL). DOES NOT WANT TREATMENT/REFERRAL . . . 3 (SIGN) (GO TO 401)
317	CHECK COVER AND INDICATE IF RESPONDENT IS FEMALE OR MALE FEMALE ☐	MALE ☐ (SKIP TO 319)
318	Are you currently pregnant?	YES . . . . . 1 → 320 NO 2
319	**GIVE DOXYCYCLINE AND SHOW RESPONDENT HOW TO TAKE THE MEDICINE.** → 321	
320	**GIVE ERTHROMYCIN AND SHOW RESPONDENT HOW TO TAKE THE MEDICINE.**	
321	**DESCRIBE POSSIBLE REACTION TO TREATMENT** It is possible that you may have fever accompanied by headache and muscle ache within 24 hours after treatment. This is a normal response to the treatment. You can take Panadol or Asperin if you have these symptoms.	
322	**PROVIDE REFERRAL FOR FOLLOWUP/FURTHER TREATMENT.** It is possible that your sexual partner may have this infection. Therefore, it is important for him/her to be tested and treated if he/she is found to be infected. If your partner does not live in this household or is not present to be tested, I can provide him/her with a referral for followup and treatment . Would you like me me to provide a referral for your partner? IF ACCEPTS, PREPARE PARTNER REFERRAL.	ACCEPTS REFERRAL . . . . . 1 DOES NOT WANT REFERRAL 2 NO CURRENT PARTNER 3

4. HIV TEST RESULT NOTIFICATION

401	CHECK 208, 209, 210, 211 AND 212 AND RECORD RESULT OF HIV TEST. POSITIVE (POSITIVE DETERMINE HIV TEST (208) AND EITHER STATPAK (210) OR UNIGOLD (212) IS POSITIVE) ☐ NEGATIVE (NEGATIVE DETERMINE, OR POSITIVE DETERMINE AND NEGATIVE STATPAK OR UNIGOLD) ☐ (INFORM THE RESPONDENT OF NEGATIVE RESULT, AND CONDUCT POST-TEST COUNSELING. **END)**
402	INFORM SURVEY PARTICIPANT ABOUT POSITIVE HIV STATUS AND PROVIDE POST-TEST COUNSELING. AS PART OF POST-TEST COUNSELING, PROVIDE A REFERRAL TO THE NEAREST HEALTH FACILITY WHERE HIV CARE AND SUPPORT SERVICES ARE AVAILABLE.
403	CHECK 203 AND INDICATE TYPE OF BLOOD COLLECTED. VENOUS ☐ CAPILLARY ☐ END
404	**CD4 TEST**

As my colleague discussed earlier, we would like to use one of the other blood tubes we collected from you to do another test. This test cannot be done in the home. We need to do it at a laboratory. The testing is to see how many CD4 cells you have. These cells help a person to stay healthy. We will send the blood for this test to a Central Laboratory at UVRI in Entebbe. We will give you a unique code with which they can get the result of your CD4 test in a health facility nearby [MENTION NAMES]. The clinic staff there will advise you on the need for treatment. The result will be ready in about 6 weeks. The results will remain available in the health facility for a period of 6 months. If the result is not picked in that period, you will have to have the tests again in a health facility providing CD4 testing services.

AGREED, WANTS RESULT . . . 1
AGREED, DOES NOT WANT RESULT 2
REFUSED 3

_____
(SIGN)

(RECORD OUTCOME OF REQUEST FOR CONSENT FOR CD4 TEST IN 214).

501 FIELD TESTING OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING TESTING AND TREATMENT

COMMENTS ABOUT RESPONDENT:

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COMMENTS ON TESTING PROCESS:

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ANY OTHER COMMENTS:

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SUPERVISOR'S OBSERVATIONS

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NAME OF THE SUPERVISOR: _____ DATE: _____