

Name of Organization: _____

First and Last name of person registering: _____

Role/title: _____

E-mail address: _____

Telephone #: _____

Area(s) in Haiti that the organization is working:

Department: _____

Arrondissement: _____

Commune: _____

Town: _____

Is your organization already performing cervical cancer screening in Haiti?

Yes No

If yes:

When did the program start? _____

What type(s) of screening does your organization offer?

HPV Testing VIAM (colposcopy)

VIA Cervical cytology

What type of treatment does your organization offer?

Cryotherapy Cryogun

LEEP Cervical conization

Hysterectomy

Approximately how many women has your program screened in the past year? ____

Please share any data that you have from your screening/treating program.

Additional comments: