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: