



**National Malaria Elimination Program**  
Malaria Quality Assurance & Quality Control

**MQC: FORM 1**  
**MALARIAL SMEARS FOR VALIDATION (CROSS-CHECKING)**  
(क्रस चेकको लागि स्लाईड पठाउँदा भर्नुपर्ने फारम)

Month: \_\_\_\_\_ Year: \_\_\_\_\_ Province: \_\_\_\_\_ District: \_\_\_\_\_

Health Facility Name: \_\_\_\_\_

Type: Provincial Hospital ☐ District Hospital ☐ PHC ☐ Designated Centers ☐ Health Post ☐ Private Hospital ☐

Other (Specify): ☐ \_\_\_\_\_

Total No. of slide examined:  Total No. of Positive:  Total No. of Negative:

S.N.	Slide ID No.	Date Examined (dd/mm/yyyy)	Species	Parasites/ $\mu$ l blood (t,s)	Parasites/ $\mu$ l blood (gametocytes)	Remarks
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

Total No. of Slide Sent:

**Examined by (LT/LA)**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

**Noted by**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

**Head of the Facility**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date of Submission: \_\_\_\_\_