



**Health protection Agency  
Ministry of Health  
Male', Republic Of Maldives**

HPA-SUR-U00067-F-2019-1

**Event#:** \_\_\_\_/20\_\_

**Event Based Surveillance**

**Current date:**

**Initial Assessment Form**

**1. Information about reporting person**

Name of the person reporting

What is your Position/designation

Contact number

email address(optional):

**2. If the report is second hand, what is the original source of reporting?**

Name:

Current Address:

Contact number

email address(optional):

**3. Give a brief description of the event, including the date of onset, location, total number of cases, total number serious cases, number of deaths if any.**

**4. If the event is an illness, give the signs and symptoms and probable diagnosis.  
Get this information from the attending doctor/Public Health Officer.**

Name:

Current Address:

Contact number:

email address(optional):

**5. Form completed by**

Name:

Current Address:

Contact number

email address(optional):

Signature:

Date:

[illegible]