*Period covered by Report:* *(month) to* *(months)* *(year)*

General Information

Please note the SRC committee will judge the development of your SRC link based on the below criteria: Primary criteria:

 1. Clinical staff training

 2. Education

 3. Upgrade of clinical services

Secondary criteria:

 1. Community-orientation including evidence of participation in World Kidney Day

 2. Clinical research activities at the EC

 3. Relay of knowledge through regional, national and international meetings and publications

SRC Information

Emerging Center (EC):

Country:

Liaison Officer name:

Liaison Officer email address:

Supporting Center (SC):

Country:

SC Main contact name:

SC Main contact email address:

Mentor Center (MC) *only for trios*:

Country:

MC Main contact name:

MC Main contact address:

Current Category: A  [ ]  B [ ]  C [ ]  HB [ ]  HC [ ]

Clinical staff training

* 1. Planned visits from Emerging Center (EC) to Supporting Center (SC) or Mentor Center (MC)

|  |
| --- |
| VISIT 1 |
| **Description of the visit***(Please describe how long was the visit in days, how many team members went and how did this visit reflect or will reflect back at the EC)* |  |  |
|       |
|
|
|
|   | **Name(s) of visitor(s)** | **Profession** | **Duration in weeks** | **Starting Date** |
| 1 |        |       |       |       |
| 2 |        |        |        |        |
|  |       |       |       |       |
| VISIT 2 |
| **Description of the visit***(Please describe how long was the visit in days, how many team members went and how did this visit reflect or will reflect back at the EC)* |  |  |
|       |
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|
|   | **Name(s) of visitor(s)** | **Profession** | **Duration in weeks** | **Starting Date** |
| 1 |        |       |       |       |
| 2 |        |        |        |        |
| 3 |        |        |        |        |

*Please enclose a separate document should you wish to add another visit, further descriptions or details*

* 1. Planned visits from Supporting Center (SC) or Mentor Center (MC) to Emerging Center (EC)

|  |
| --- |
| VISIT 1 |
| **Description of the visit***(Please describe how long was the visit in days, how many team members went and how did this visit reflect or will reflect back at the EC)* |  |  |
|        |
|
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|
|
|   | **Name(s) of visitor(s)** | **Profession** | **Duration in weeks** | **Starting Date** |
| 1 |        |       |       |       |
| 2 |        |        |        |        |
| 3 |       |       |       |       |
|  |  |  |
| VISIT 2 |
| **Description of the visit***(Please describe how long was the visit in days, how many team members went and how did this visit reflect or will reflect back at the EC)* |  |  |
|        |
|
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|
|   | **Name(s) of visitor(s)** | **Profession** | **Duration in weeks** | **Starting Date** |
| 1 |        |       |       |       |
| 2 |       |       |       |       |
| 3 |        |        |        |        |

Education

* 1. ISN GO Programs involvement

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| CME Program |
| Did you hold any ISN funded CMEs? Yes [ ]  No[ ]  If yes;Date of the event:      Venue of the event:       **How did your centers benefit from the meeting?**

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 **Please rate the success of the meeting (1 being the lowest)**1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  |   |  |

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| --- |
| Fellowship Program |
| Have you sent or hosted a Fellow with the ISN Fellowship Program funds? Yes [ ]  No[ ]  If yes;Name:      Duration of training:       *(in months)*Training Topic:       **What was the impact of the visit?**

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 **Please rate the success of the meeting (1 being the lowest)** 1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]

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| --- |
| Educational Ambassador Program |
| Have you sent or hosted an ISN Educational Ambassador? Yes [ ]  No[ ]  If yes;Name:      Duration of training:       *(in months)*Training Topic:       **What was the impact of the visit?**

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 **Please rate the success of the meeting (1 being the lowest)** 1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  |  |  |
| Clinical Research and Prevention Program |
| Have you conducted an ISN funded clinical research and prevention project? Yes [ ]  No[ ]  If yesName of the project:      Research project Duration of training:       *(in months)* **What has been the impact of this research and prevention project on the EC?**

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 **Please rate the success of the meeting (1 being the lowest)** 1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ] * 1. Other (such as educational material or educational activities that are non ISN program)
1. Educational material

Did the SC/MC provide any educational material (CDs, Journals, text book)? Yes [ ]  No[ ]  If yes, what was provided?

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 **Please rate how the EC benefited from those materials (1 being the lowest)** 1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ] Any Comments?      1. Others (i.e: attendance on training courses whilst on training attachment at the EC … )

Please describe

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|  **Please rate how the EC benefited from those materials (1 being the lowest)** 1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ] Any Comments?       |

 |  |  |

3. Upgrade of clinical services

|  |
| --- |
| PROJECT 1 |
| **Description of project** |  |  |
|        |
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| --- |
| PROJECT 2 |
| **Description of project** |  |  |
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*Please enclose a separate document should you wish to add another visit, further descriptions or details*

4. Other relevant activities

Including community orientation activities – such as WKD, clinical research and relay of knowledge

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| --- |
| PROJECT 1 |
| **Description of project** |  |  |
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| --- |
| PROJECT 2 |
| **Description of project** |  |  |
|        |
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*Please enclose a separate document should you wish to add another visit, further descriptions or details*

5. Greatest achievements and disappointments

Please describe your greatest achievements and disappointments (Maximum 250 words)

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6. Summary of Expenditures

a. ISN funded activities

Please list the activities undertaken since the beginning of the period covered by the report that were funded with the ISN SRC program budget. Kindly indicate how much budget was spent for each of them.

|  |  |  |
| --- | --- | --- |
| **#** | **Description**(please indicate the names of the people involved, dates and place) | **Expenditure** (USD) |
| 1 |       |       |
| 2 |       |       |
| 3 |       |       |
| 4 |       |       |
| 5 |       |       |

* 1. Other funded activities

Please list the activities undertaken since the beginning of the period covered by the report funded from other sources and indicate how much budget was spent for each of them.

|  |  |  |
| --- | --- | --- |
| **#** | **Description**(please indicate the names of the people involved, dates and place) | **Expenditure** (USD) |
| 1 |       |       |
| 2 |       |       |
| 3 |       |       |
| 4 |       |       |

Signatures

Emerging Center Liaison Officer

EC Liaison Officer name:

Signature:

Supporting Center Liaison Officer

SC Main contact name:

Signature:

Mentor Center Liaison Officer *(only for trio)*

MC Main contact name:

Signature: