**CSO IMPLEMENTING: VALIDATION REPORT**

**VALIDATION REPORT (TEMPLATE)**

DSWD-FO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Requested SB to validate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Validated by FO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of FOs submission of report to SB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following are the prescribed content of the Validation Report on the CSO’s operations in the region.

1. Identifying Information

A.1. If the CSO has an office in the region:

* Name of CSO
* Address
* CSO Region Head and Designation
* Telephone/Mobile/Fax Number/s
* E-mail address
* Website
* Picture of the visited CSO site

A.2. If the CSO is found not existing nor operating in the region despite exhausted efforts to locate, there’s no need to fill up other parts of this template.

B. If the CSO does not have an office in the region but has existing partners operating in a tie-up scheme:

* Contact details of the focal person/coordinator such as name, address, telephone/mobile number/s, e-mail, etc.; or
* Contact details of partner agency such as name of agency, name of focal person, address, telephone/mobile number/s, e-mail, etc.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Coordinator/  Partner agency | Address | Phone number | Email address |
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| **Projects and/or Programs** | **Brief description on how the CSO implements the Technical areas of expertise** | **Period started- Program timelines (regular, seasonal, semestral,year round, yearly, biennial etc.)** | **Geographical Areas of Coverage (pls. indicate specific location)** | | **Target Clientele**  **(pls. indicate specific sector)** |
| Province | City/Municipality  Barangay |
| Delivery of basic social welfare services |  |  |  |  |  |
| Disaster risk reduction and management program |  |  |  |  |  |
| Livelihood development assistance |  |  |  |  |  |
| Center based services |  |  |  |  |  |
| Community based social welfare programs and services |  |  |  |  |  |

1. Program Profile

* List of beneficiaries benefitting from the program/project
* Memorandum of agreement (MOA)/ Memorandum of Understanding (MOU) with partner agencies

1. Personnel

If the CSO has an office in the region, kindly fill-up the following matrix.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No. of Staff | Staff Complement | | | |
| Full Time/Regular Staff | Project-Based Staff | Part-time Staff | Volunteer |
| Technical Staff |  |  |  |  |
| Administrative Staff |  |  |  |  |
| Total |  |  |  |  |

1. Source of Funds – Please specify the CSO’s sources of funds, whether government or private organizations/individuals, local and/or foreign/international including other resource generation activities.
2. Other information gathered necessary to the assessment (if any)

* Supporting documents relative to the declared implemented or current projects and/or programs.

1. Source of information – (Please specify the sources of information. If there are other information gathered aside from the CSO representative, kindly indicate)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Source of information | Designation | Name of Agency (if not the CSO being validated) | Address | Contact Person |
| MSWD/CSWD Personnel/Others (pls. specify) |  |  |  |  |
| (Beneficiaries) |  |  |  |  |

7. Remarks

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Validated by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Signature of DSWD-FO Standards Section Staff and Designation Date

Concurred by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Signature of Immediate Supervisor and Designation Date

Endorsed by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Signature of FO Director or Authorized Representative and Designation Date

\* Validation Report may not be needed as per Sec. VI. Accreditation Process Item 3.4 of

Validation.