SUPPORTING STATEMENT FOR
FEDERALLY SPONSORED DATA COLLECTION

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
ORAL HEALTH MANAGEMENT INFORMATION SYSTEM

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ATTACHMENT 5

PORPOSED MIS DATA COLLECTION INSTRUMENT

Form Approved
OMB NO._____
Exp. Date _____

Division of Oral Health

Semi-Annual Progress Report

Public reporting burden of this collection of information is estimated to average 9 hours per response (semi-annual and annual report), including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ASTDR Reports Clearance Officer; 1600 Clifton Road NE, MS D024, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

Overview
The following table defines the data proposed for collection through the CDC Division of Oral Health Information System (DOH IS). For each key section, the question and response options are identified. If the response option is labeled "text", the responder can enter free form text. Questions marked with an asterisk (*) indicate a required question.

Information Sections
The data collected is grouped according to the key sections listed below.
General Program Information
Staff
Partners
Contracts
Statewide/Community-Based Coalition
Budget Detail And Justification
Systemic, Socio-political, and Policy Change Assessment
Disease Burden, Priority Population, and Unmet Needs
Data Sources
Work Plan Objectives
Work Plan Objective Progress
Work Plan Activities
Work Plan Activity Progress
Work Plan Products

General Program Information

Question	Response Options
Program Contact Information	
Mailing address line 1*	Text
Mailing address line 2	Text
Mailing city*	Text
Mailing state*	Select from list of states
Mailing zip*	Text
Shipping address line 1*	Text
Shipping address line 2	Text
Shipping city*	Text

Shipping state*	Select from list of states
Shipping zip*	Text
Program telephone*	Number
Program fax	Number
Program web address	Text
Principle Investigator*	Text
Principle Investigator Telephone*	Text
Business Official*	Text
Business Official Telephone*	Text
Funded for fluoridation program (10A)?*	Yes/No, list first year of funding
Funded for sealant program (10B)?*	Yes/No, list first year of funding
Program Overview	
Program type*	Select one: Capacity Building Basic Implementation
Program summary*	Text
Program goals*	Text
Organization Chart	
File name*	Text
Type*	Select one: Overall state health structure State health agency structure Oral health program structure
Date last revised*	Month and Year

Staff

Question	Response Options
First name*	Text
Middle name	Text
Last name*	Text
Credentials	Text
Address same as program mailing address	Select one: Yes No
Address line 1*	Text
Address line 2*	Text
City*	Text
State*	Text
Zip*	Number
Telephone*	Number
E-mail address*	Text
Position title*	Text

Question	Response Options
Overall oral health program time allocation*	Percent
Program time allocation working on cooperative agreement*	Percent
Primary role within oral health program*	Select one: Administrative support Agency manager Budget manager Coalition coordinator Community developer Computer technology support Cooperative agreement program contact Data analyst Data manager Dental consultant Dental director Dental sealant coordinator Epidemiologist Evaluation specialist Fluoridation engineer Fluoridation specialist/coordinator Grant writer Health communication specialist Health educator MIS contact Policy developer Principle investigator Program coordinator Program manager Regional consultants Web designer Other (specify)
Indicate all roles performed including the primary role of this staff member and the percent of overall program time allocation for each role. * (the total of all roles FTE must add up to the overall FTE)	Select all that apply: Role — % of Overall FTE Administrative support — Percent Agency manager — Percent Budget manager — Percent Coalition coordinator — Percent Community developer — Percent Computer technology support — Percent Data analyst — Percent

Question	Response Options
	Data manager Percent Dental consultant Percent Dental director Percent Dental sealant coordinator Percent Epidemiologist Percent Evaluation specialist Percent Fluoridation engineer Percent Fluoridation specialist/coordinator Percent Grant writer Percent Health communication specialist Percent Health educator Percent MIS contact Percent Policy developer Percent Program coordinator Percent Program manager Percent Regional consultants Percent Web designer Percent Other (specify) Percent
What percent of the primary role's overall FTE is funded by CDC DOH? *	Percent
Please identify what other sources fund this staff member's salary*	Select all that apply: Permanent state dollars One-time only state dollars CDC/DOH core dollars CDC/DOH supplemental dollars Maternal Child Health block grant CDC prevention block grant Other (specify)
Employment type*	Select one: State employee State outsourced contract Temporary state employee Other (specify)
Date started with state oral health program*	Month and Year
Date finished with state oral health program	Month and Year
Curriculum vitae/resume*	Text – file name
Date last revised	Month and year

Partners

Question	Response Options
Partner organization*	Text
Contact first name*	Text
Contact last name*	Text
Address line 1	Text
Address line 2	Text
City	Text
State	Text
Zip	Number
Telephone	Number
E-mail address	Text
Website	Text
Partner Status*	Select one: Active Inactive
Is this partner a member of a statewide or community-based oral health coalition?*	Select one: Yes (Select coalition) No
Partner level*	Select one: National Regional State District/Local
Partner type*	Select up to 3: Academia/education Advocacy group An Individual Business/industry sector Civic organization Community based organization Community health center Cultural organization District or local government agency Environmental agency Faith-based organization Federal government agency Foundations Healthcare organization Nonprofit organization Other government agency Organization representing priority population Prevention research center Professional association

Question	Response Options
	Public health official Quality improvement organization State government agency Volunteer agency Other (specify)
Contributions*	Select all that apply: Communication network access Conference sponsor Consultation Data analysis Epidemiology Equipment Evaluation Funding Media Personnel Supplies and equipment Training/education Travel assistance Visibility (credibility) Other (specify)
Evidence of collaboration*	Select all that apply: Joint dedication of resources Letter of support Memorandum of agreement (MOA) Memorandum of understanding (MOU) Other (specify)

Contracts

Question	Response Options
Organization name*	Text
Contact first name*	Text
Contact last name*	Text
Address line 1	Text
Address line 2	Text
City	Text
State	Text
Zip	Number
Telephone	Number
E-mail address	Text
Website	Text
Is this contractor fulfilling the role of a staff member for the state health	Select one: Yes

Question	Response Options
department*	No
Primary role(s)*	Select all that apply: Administrative support Coalition coordination Community development Computer technology/support Data analysis Data collection Data management Dental sealant coordination Epidemiologist Evaluation Facilitator Fluoridation engineering Fluoridation coordination Grant writing Health communication Health education Meeting/conference facilitation Policy development Program consultant Public relations Regional consultants Training Web/Application designer Other (specify)
Contract amount*	Number
Contract Attachment*	File Name - Text
Date Last Revised*	Date
Type*	Select one or more: Meeting minutes Method of accountability Method of selection Period of performance Scope of work

Statewide/Community-Based Coalition

Question	Response Options
Coalition Name*	Text
Type*	Select one: Community Regional

Question	Response Options
	Statewide Other (Specify)
Number of members	Number
Member composition*	Select all that apply: Government: Social services Environmental health State/Local Health Department Interagency and/or Interdepartmental Steering Committee Other (specify) Community: Business leader Community water supervisor/manager Community-based clinic Faith-based organization Foundation Local community health department Other (specify) Education: Local school administrator Parent Teacher Association School nurse association Education Regional staff Other (specify) Third Party Payers: Insurance Managed care Medicaid Other (specify) Policy Makers: Federal legislator Local/community policy maker Policy advocate State legislator Other (specify)
Meeting frequency*	Select one: Monthly

Question	Response Options
	Quarterly Semi-annually Annually Other (specify)
Priority focus areas*	Select all that apply: Infants and toddlers Children Adolescents Adults Older adults Access Aging population Assessment Caries Communications/marketing Disparity Education Evaluation Fluoridation Funding Infection control Infrastructure Injury prevention Oral and systemic disease Oral cancer Periodontal disease Policy Program/system sustainability Sealants Surveillance Tobacco cessation Work force Other (specify)
Does a specific group within the coalition address any of the following priority areas?*	Infrastructure Yes No Fluoridation Yes No N/A, HP2010 has been met Sealants Yes No

Question	Response Options
	N/A, HP2010 has been met
List Any Coalition Sub-Groups	Text
Sustainability evidence type*	Select all that apply: 501c3 status By-laws Clerical staff support Established internal communication network Evaluation of coalition and coalition activities Funding and institutionalization Stakeholder maintenance/list Letter of support Leveraging resources Meeting minutes/schedules Membership maintenance/list Memorandum of agreement/understanding Policy development Products & impact SMART action plan development and implementation Visibility Written priorities/plans/strategies Written vision/mission statements Other (specify)
Attachment*	File Name - Text
Date Last Revised*	Date
Type*	Select all that apply: 501c3 status By-laws Clerical staff support Established internal communication network Evaluation of coalition and coalition activities Funding and institutionalization Stakeholder maintenance/list Letter of support Leveraging resources Meeting minutes/schedules Membership maintenance/list Memorandum of agreement/understanding Policy development Products & impact SMART action plan development and implementation Visibility Written priorities/plans/strategies

Question	Response Options
	Written vision/mission statements Other (specify)

Budget Detail and Justification

Question	Response Options
Personnel	
Budget type	Display only
Personnel*	Select from list
Position Title	Display only
Yearly salary*	Number
% of time	Display only
Number of months per year*	Number
Amount	Number
Justification*	Text
Allocation*	Enter each Federal requested amount or % State cash amount or % State in-kind amount or % Other cash amount or % Other in-kind amount or %
Fringe benefit rate*	Percent
Fringe amount	Number
Fringe allocation*	Enter each Federal requested amount or % State cash amount or % State in-kind amount or % Other cash amount or % Other in-kind amount or %
Travel	
Budget type*	Select one: Base funding Supplemental Carryover (Specify year)
Trip title*	Text
Type*	Select one: Instate Out of state

Question	Response Options
Number of people*	Number
Number of trips*	Number
Dates of Travel	Enter date range
Per diem	Number
Mileage	Number
Ground transportation	Number
Airfare	Number
Lodging	Number
Car rental	Number
Other	Number
Amount	Number
Justification*	Text
Allocation*	Enter each Federal requested amount or % State cash amount or % State in-kind amount or % Other cash amount or % Other in-kind amount or %
Equipment	
Budget type*	Select one: Base funding Supplemental Carryover (Specify year)
Equipment title*	Text
Number of units*	Number
Cost per unit*	Number
Amount	Number
Justification*	Text
Allocation*	Enter each Federal requested amount or % State cash amount or % State in-kind amount or % Other cash amount or % Other in-kind amount or %
Supplies	
Budget type*	Select one: Base funding Supplemental Carryover (Specify year)
Supply title*	Text

Question	Response Options
Number of units*	Number
Cost per unit*	Number
Amount	Number
Justification*	Text
Allocation*	Enter each Federal requested amount or % State cash amount or % State in-kind amount or % Other cash amount or % Other in-kind amount or %
Contractual	
Budget type*	Select one: Base funding Supplemental Carryover (Specify year)
Organization name	Select from list
Primary role	Display only
Amount*	Number
Justification*	Text
Scope of work*	Text
Method of accountability*	Text
Period of performance*	Enter date range
Method of determination*	Text
Allocation*	Enter each Federal requested amount or % State cash amount or % State in-kind amount or % Other cash amount or % Other in-kind amount or %
Travel costs included?*	Select one: Yes No
Type*	Select one: Instate Out of state
Number of people*	Number
Number of trips*	Number
Dates of Travel	Enter date range
Per diem	Number

Question	Response Options
Mileage	Number
Ground transportation	Number
Airfare	Number
Lodging	Number
Car rental	Number
Other	Number
Amount	Number
Other	
Budget type*	Select one: Base funding Supplemental Carryover (Specify year)
Description*	Text
Amount*	Number
Justification*	Text
Allocation*	Enter each Federal requested amount or % State cash amount or % State in-kind amount or % Other cash amount or % Other in-kind amount or %
Indirect Charges	
Budget type*	Select one: Base funding Supplemental Carryover (Specify year)
Indirect charge rate*	Percent
Indirect charge base* (Object class categories against which the indirect rate is applied.)	Select all that apply: Personnel Fringe benefits Travel Equipment Supplies Contractual Other
Comments*	Text
Amount	Display only
Allocation*	Enter federal requested amount or %

Systemic, Socio-political, and Policy Change Assessment

Question	Response Options
Assessment title*	Text
Date of assessment*	Date
Next expected assessment date*	Date
Level*	Select all that apply: State Region within state Local Other (specify)
Frequency of assessment*	Select one: Quarterly Semi-annually Annually Bi-annually Every ___ years
Describe process for conducting the assessment (methodology)*	Text
Summarize opportunities identified (findings)*	Text
Change as a result of the assessment (use of findings)*	Text
Stakeholders involved in the developing, conducting, analyzing or evaluating the assessment?	Text
Additional assessment information	Upload attachment
Date last revised	Date

Disease Burden, Priority Population, and Unmet Needs

Question	Response Options
Title*	Text
Status*	Select one: Draft Published
The following questions relate to DRAFT burden documents	
Anticipated Publish Date	Date
Describe Progress to Date	Text
The following questions relate to PUBLISHED burden documents	
Date Published*	Date

Question	Response Options
Date Last Revised	Date
Upload or Web Address	Upload attachment or enter Web URL
Dissemination*	Select all that apply: Academia/school Advisory/partner group Business/industry sector Coalition Federal health government agency General public Governor and staff Hospital/health care agency Legislator Local health government agency Media National organization and state affiliate Other federal government agency Other local government agency Other state government agency Priority population organization Private/public policy maker State health government agency Third party payers Other (specify)
Identify the target population(s) from the burden report*	Race Select all that apply: African American or Black American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander White Not specified Ethnicity Select one: Hispanic or Latino Not Hispanic or Latino Not specified Gender Select all that apply: Female

Question	Response Options
	Male Geography Select all that apply: City County/parish Community Other (specify) Age: Select all that apply: 0-5 years 6-11 years 12-19 years 20-49 years 50-64 years 65 + Not specified Income: Select all that apply: Medicaid eligible 100% of poverty (poor) 200% of poverty (near poor) At or below 235% of poverty Not Specified
Additional target population comments*	Text
Identify the data sources used for the burden report	Select all that apply: ASTDD State Synopsis Basic Screening Surveillance (BSS) Behavioral Risk Factor Surveillance System (BRFSS) Centers for Medicare and Medicaid Services (CMS) Chronic Disease Indicators (CDI) Dental, Oral and Craniofacial Data Resource Center (DRC) Health Plan Employer Data and Information Set (HEDIS) Hospital Discharge Data My Water's Fluoride (MWF) National Health and Nutrition Examination Survey (NHANES) National Immunization Survey (NIS)

Question	Response Options
	National Oral Health Surveillance System (NOHSS) Pregnancy Risk Assessment Monitoring System (PRAMS) U.S. Bureau of Census Vital statistics Woman, Infants, and Children (WIC) Youth Risk Behavior Surveillance System (YRBSS) Youth Tobacco Survey (YTS)
Burden report includes indicators consistent with*	Select all that apply: National Oral Health System (NOHSS) Percentage of people who visited the dentist or dental clinic within the past year. Percentage of people who had their teeth cleaned in the past year. Percentage of people aged 65 years and older who have lost all natural permanent teeth. Percentage of people served by public water systems who receive fluoridated water. Percentage of 3rd grade students with caries experience, including treated and untreated tooth decay. Percentage of 3rd grade students with untreated tooth decay. Percentage of 3rd grade students with dental sealants on at least one permanent molar tooth. Cancer of the oral cavity and pharynx No data available ASTDD State Synopsis Population served by public water system Percentage of people on public water systems receiving fluoridated water. Number of dental hygiene schools Number of community-based low-income dental clinics Number of school-based health centers with an oral health component Number of tribal, state, or local agencies with service populations of 250,000 or more Number of agencies with a dental program Number of dental programs directed by a dental professional Number of directors with an advanced public health

Question	Response Options
	degree Number of dentists in the state No data available Water Fluoridation Reporting System (WFRS) Communities and populations receiving new or replacement fluoridation equipment. Percent of fluoridated water systems consistently maintaining optimal levels of fluoride as defined by No data available
Burden report includes description of*	Select all that apply: Oral health burden Oral health unmet needs Oral health disparities
Additional burden document information or publications	Enter text (100 words/500 characters) -AND/OR- Upload file

State Plan

Question	Response Option
Plan status	Select one: Draft Published
The following questions relate to DRAFT plans	
Working Title*	Text
Anticipated Publish Date*	Date
The following questions relate to PUBLISHED plans	
Published Title*	Text
Timeframe*	Date
Date Published*	Date
Date Last Revised*	Date
Attach Plan	Upload file
Dissemination of Plan*	Select all that apply: Academia/school Advisory/partner group

Question	Response Option
	Business/industry sector Coalition Federal health government agency General public Governor and staff Hospital/health care agency Legislator Local health government agency Media National organization and state affiliate Other federal government agency Other local government agency Other state government agency Priority population organization Private/public policy maker State health government agency Third party payer Other (specify)
Content Areas*	Select all that apply: Burden of disease Caries Evaluation strategies and recommendations for monitoring the outcomes and impacts of plan implementation Healthy People 2010 objectives Implementation strategies Infection control Leveraging of resources Oral cancer Oral health infrastructure Partnerships Periodontal diseases Plan maintenance Priority populations School-based or school-linked sealant programs Strategies to address oral health promotion across the lifespan Strategies to identify best practices Water fluoridation Other (specify)
Does the plan include specific, measurable and time phased objectives?*	Select one: Yes No

Surveillance Plan

Question	Response Option
Plan status	Select one: Draft Final
The following questions relate to DRAFT plans	
Working Title*	Text
Anticipated Completion Date*	Date
The following questions relate to FINAL plans	
Title*	Text
Time Frame*	Dates
Date Completed*	Date
Date Last Revised	Date
Has a logic model been developed for the plan?*	Select one: Yes No Currently being developed
Attach Plan* (Attach logic model, surveillance grid and narrative)	Upload file
Identify the data sources used for the surveillance plan*	Select all that apply: [Display list of data sources already entered]

Evaluation Plan

Question	Response Option
Evaluation Type*	Select one: Overall (required for evaluation plan and logic model) Leadership Oral disease burden, health disparities, and unmet needs Comprehensive state oral health plan Statewide oral health coalition (required for logic model) Oral disease surveillance system (required for logic model) Opportunities for systemic, socio-political and/or policy change Partnerships Limited community water fluoridation program management State program accomplishments, best practices, lessons learned, and use of evaluation results Water fluoridation program (logic model and evaluation plan required if funded) Limited school-based or school-linked dental sealant program (logic model and evaluation plan required if funded) Other (Specify)
Stage of Plan*	Select one: Not started Planning Implementation
The following questions relate to the NOT STARTED stage	
Anticipated Planning Date*	Date
The following questions relate to the PLANNING or IMPLEMENTATION stage	
Time Frame (Required if stage = implementation)	Dates
Logic Model (Required if stage = implementation)	Select one: Yes No

Question	Response Option
Stakeholders Involved (Required if stage = implementation)	Select one: Yes No
Evaluation Questions (Required if stage = implementation)	Enter text (200 words/1000 characters)
Data Sources Used (Required if stage = implementation)	Select all that apply: [list of data sources already entered]
Tools Used (Required if stage = implementation)	Select all that apply: State Plan Oral Health State Plan Index State Plan Index Coalitions Starting a Coalition Checklist Initial Coalition Survey Risk Factors for Collaborative Participation Worksheet Coalition Effectiveness Inventory (CEI) Partnership Self-assessment Member Satisfaction Survey Meeting Effectiveness Inventory Sealants Sealant Provider Survey Sealant Placement Survey School/Community Follow up survey Staff and Volunteer Satisfaction Survey Tracking Program Implementation Sealant Program Cost Analysis/ImprovePro Sealant Follow-up form Surveillance Surveillance System Evaluation Tool Other (specify)
Evaluation Design Plan (Required if stage = implementation)	Select one: Yes No
Use of Evaluation	Enter text (200 words/1000 characters)
Attachments	Upload file
Date last revised*	Date
Type*	Select all that apply: Evaluation Plan Reports

Question	Response Option
	Presentation Tools Other (Specify)

Work Plan Objectives

Question Asked	Response Option
Specific	
Objective Title*	Text
Objective Status*	Select one: Proposed In progress Completed Deferred Cancelled
Related 5-Year Goal*	Select all that apply: Develop Oral health program leadership capacity. Describe the oral disease burden, health disparities, and unmet needs in the State. Develop or update a comprehensive State Oral Health Plan. Establish and sustain a diverse Statewide oral health coalition. Develop or enhance oral disease surveillance system. Identify prevention opportunities for systemic, socio-political and/or policy change to improve oral health. Develop and coordinate partnerships to increase State-level and community capacity to address specific oral disease prevention interventions. Coordinate and implement limited community water fluoridation program management. Evaluate, document, and share State program accomplishments, best practices, lessons learned, and use

Question Asked	Response Option
	of evaluation results. Develop and Implement a water fluoridation program. Develop, coordinate and implement limited school-based or school-linked dental sealant programs.
Measurable & Achievable	
Measure of success*	Select all that apply (based upon selected 5-Year Goal): Develop Oral health program leadership capacity. existence of full-time dental director existence of .25 time epidemiologic support access to at least .50 time of a water fluoridation engineer/specialist or coordinator access to .50 to one time dental sealant coordinator access to .25 time capacity for health education, health communication access to .25 time support staff Describe the oral disease burden, health disparities, and unmet needs in the State. disease burden document is publicly available. disease burden document includes oral health status with indicators consistent with the National Oral Health System (NOHSS), the Water Fluoridation Reporting System (WFRS), and the ASTDD State Synopsis. Develop or update a comprehensive State Oral Health Plan. plan addresses oral health infrastructure including current plan addresses evaluation strategies and recommendations for monitoring the outcomes and impacts of plan implementation Establish and sustain a diverse Statewide oral health coalition. progress towards coalition sustainability Develop or enhance oral disease surveillance system. establishment of a plan for how data collection, analysis, and dissemination will support program activity, including a surveillance plan logic model consistent with the CDC Surveillance Logic model Identify prevention opportunities for systemic, socio-political and/or policy change to improve oral health.

Question Asked	Response Option
	periodic assessments to demonstrate identification of socio-political and policy changes.
Baseline*	Text – OR – Select ‘Baseline unknown’
Target*	Text
Evidence for measuring target*	Text
If baseline is unknown, explain how it will be determined.	Text
Relevant	
Describe how this objective will establish, strengthen or expand your program’s capacity to plan, implement, and evaluate population-based oral disease prevention and health promotion programs, targeting populations and oral disease burden.*	Text
Time-bound	
Start Date*	Date
End Date*	Date

Work Plan Objective Progress and Results

Question Asked	Response Option
Progress	
Date progress occurred*	Date
Describe progress*	Text
Has the objective’s target been met?*	Select one: Yes No Currently ongoing
Results if Objective Target is Met	
Enter date met*	Date

Question Asked	Response Option
Measure achieved*	Text
Facilitating factors for success*	Text
Describe barriers encountered while achieving the objective's target measure	Text
Describe any unanticipated outcomes or collateral effects	Text
Results if Objective Target is Not Met or Currently Ongoing	
Current measure (if applicable)	Text
Describe barriers to achieving the objective's target measure	Text
Describe plans to overcome barriers	Text
Describe any unanticipated outcomes or collateral effects	Text
Objective Revisions	
Does the objective status, start date, end date or target measure need to be revised?*	Select one: Yes No
Revise objective status	Select one: Proposed In Progress Completed Deferred Cancelled
Explain reason for revising status	Text Required only if status is revised to ‘Deferred’ or ‘Cancelled’
Revise objective start date	Date
Explain reason for revising start date	Text Required only if start date is delayed
Revise objective end date	Date
Explain reason for revising end date	Text Required only if end date is extended

Question Asked	Response Option
Revise objective target measure	Text
Explain reason for revising target measure	Text Required for all target measure changes

Work Plan Activities

Question Asked	Response Option
Activity Title*	Text
Activity Description*	Text
Status*	Select one: Proposed In progress Completed Deferred Cancelled
Lead staff assigned to this activity*	Select one: [list of existing staff]
Other staff assigned to this activity	Select all that apply: [list of existing staff]
Contractors assigned to this activity	Select all that apply: [list of existing contractors]
Partners assigned to this activity	Select all that apply: [list of existing partners]
Describe partner involvement	Text
Start Date*	Date
End Date*	Date

Work Plan Activity Progress

Question Asked	Response Option
Progress	
Date progress occurred*	Date
Describe progress*	Text
Activity Revisions	
Does the activity status, start date or end date need to be revised?*	Select one: Yes No

Question Asked	Response Option
Revise activity status	Select one: Proposed In Progress Completed Deferred Cancelled
Explain reason for revising status	Text Required only if status is revised to ‘Deferred’ or ‘Cancelled’
Revise activity start date	Date
Explain reason for revising start date	Text Required only if start date is delayed
Revise activity end date	Date
Explain reason for revising end date	Text Required only if end date is extended

Work Plan Products

Question Asked	Response Option
Products	
Title*	Text
Description*	Text
Website Address	Text
Attachments	Upload File
Date file last revised	Date
Can this document be shared?	Select one: Yes No