

PTID		VISIT DATE (DD/MMM/YY)		VISIT CODE		Staff Initials & Date	
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**Read the following statement to the participant before administering the eligibility worksheet:**

“I am now going to ask you some questions about yourself. You already answered many of these questions at your screening visit, but I need confirm these things again today before you enroll. Some of these questions are personal and sensitive, but remember that we do not have your name on these papers. All of your answers will be kept confidential.”

**To confirm eligibility for the study, ask the participant the following questions and mark her responses accordingly.**

1.	Are you currently exclusively breastfeeding one infant (and not more than one) and do you plan to continue exclusive breastfeeding of that infant for the duration of your study participation (about 4.5 months)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Are you available for all visits and willing and able to comply with all study requirements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Are you currently using an effective form of contraception and do you plan to continue use for the duration of the study? Effective methods include contraceptive implants, intrauterine device, injectable progestin, oral contraceptive pills, and surgical sterilization.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	During your and your infant’s study participation, do you plan to stay within the study clinic area and are you willing to give accurate locator information?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	Are you willing to be assigned to either the pill or ring by chance (randomized) when you enroll in the study and continue to use that assigned product for at least 12 weeks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	Have you used post-exposure prophylaxis (PEP) for HIV prevention after possible HIV exposure in the last 6 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	Have you used any vaginal medications or products within the past 5 days?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.	Have you used a needle to inject drugs that were not prescribed to you by a medical professional in the past 12 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.	Have you in the past 30 days, or are you currently, participating in any other research studies involving drugs, medical devices, vaginal products or vaccines?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10.	During participation in this study, do you plan to participate any other research studies involving drugs, medical devices, vaginal products or vaccines?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11.	Is your infant currently participating in any other research studies involving drugs, medical devices, or vaccines or has your infant ever participated in research like this?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12.	During participation in this study, do you expect your infant to participate any other research studies involving drugs, medical devices, or vaccines?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**For the participant to be eligible, the responses to items 1-5 above must be “Yes” and responses to items 6-12 above must be “No.”**