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| ***Closed POD Partner Enrollment Form*** |

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| **X** | **Yes, we want to participate as a POD partner** |

In the event of a large-scale public health emergency that would require distribution of medication(s), we would like to do our part to dispense medication(s) to our identified population. We understand that completing this enrollment form is not a binding contract.

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| **Organization and Coordinator Information** | | | | | | | | | |
| Name of Organization: | |  | | | | | | | |
| Street Address: | |  | | | | | | | |
| PO Box: | |  | | | | | | | |
| City: | |  | | State: | |  | | Zip code: |  |
| Telephone: | |  | Email: | | |  | | | |
| Fax Number: | |  |  | | |  | | | |
|  | | | | | | | | | |
| **Primary Coordinator** | | | | | | | | | |
| Name: |  | | |  | Position/Title: | |  | | |
| Work Phone: |  | | |  | Home Phone: | |  | | |
| Email: |  | | |  | Cell/Pager: | |  | | |

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| **First Backup Coordinator** | | | | |
| Name: |  |  | Position/Title: |  |
| Work Phone: |  |  | Home Phone: |  |
| Email: |  |  | Cell/Pager: |  |

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| **Second Backup Coordinator** | | | | |
| Name: |  |  | Position/Title: |  |
| Work Phone: |  |  | Home Phone: |  |
| Email: |  |  | Cell/Pager: |  |

**Estimate Identified Population**

Please provide information below:

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| --- | --- | --- | --- |
| Total Number of Employees, including contractors: |  |  |  |
| *\*To estimate the number of family members, multiply the number of employees by 3.2\**  *\* adjust for district numbers based on population estimates* |  | **(Remove box)** |
| Patients/Residents (if applicable) |  |
| Students (if applicable) |  |  |  |
| Total |  |  |  |
|  |  |  |  |

**Additional Information**

As a POD Partner, we understand that we would be eligible to receive antibiotics and medical supplies at no cost should the local public health authorities notify us of a public health emergency and decide to activate this agreement. We understand that my organization or business may decline to participate in this program at any time.

**We understand the primary planning assumptions of this agreement are:**

1. A Public Health Emergency has occurred that is too large to be managed with local and state resources. Medical countermeasures from the federal Strategic National Stockpile (SNS) have been deployed to supplement local and state resources.

2. A Federal Declaration of Disaster has been declared.

3. Due to the nature of the public health emergency, Georgia pharmaceutical dispensing laws maybe relaxed to allow for the implementation of the non-medical dispensing modality.

**We agree to the following conditions:**

We agree to identify a licensed health care professional (physician, pharmacist, registered nurse, nurse practitioner, physician’s assistant) to oversee the dispensing of the medication.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. We agree to provide the local public health authorities with an estimated number of our identified populations to be served.
2. Our facilities that will serve as POD sites will follow the most current guidance from the CDC that is approved by the state and/or local public health authorities.
3. A representative from each of our facilities that will be serving as a POD site will pick up medications and supplies from the pre-designated pick up site(s). Our organization will provide the local public health authorities with the name of the representative(s) picking up the medications prior to pick up.
4. The representative(s) picking up the medications and supplies will provide a photo ID.
5. The representative(s) will sign for all medications and supplies received.
6. Our organization will notify the local public health authorities when the supplies reach any of our facilities that will be serving as a POD site and if there are any discrepancies between the quantity ordered and the quantity delivered.
7. Our facilities that will be serving as POD sites will be responsible for administration of the medication, distribution of information sheets, and collection of completed intake forms. Intake forms will be returned to the local public health authorities.
8. Our organization will be responsible for returning any unused medication to the local public health authorities.
9. Our organization agrees to not charge for the medication or for any of the services provided as a part of the administration of the medication.
10. Either organization may terminate this agreement at any time.

**Authorization by our organization to become a Closed POD Partner:**

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|  |  |  |
| Name *(please print clearly*) |  | Title |
|  |  |  |
| Signature |  | Date |

**You may return the form in any one of three ways:**

1. FAX: 706-583-2827

2. Mail: 189 Paradise Blvd. Athens, GA 30607

3. Email: Scan a copy and email to Elisabeth.Wilson@dph.ga.gov

**Please return the original and save a copy to complete various sections of your Dispensing Plan**

**If you have any questions, please contact Elisabeth Wilson at Elisabeth.Wilson@dph.ga.gov**

**Thank you for enrolling to become a POD Partner!**