Private Industry POD Partner Enrollment Form

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 medications to the public, we would like to do our part to dispense medications to our employees, the family members of our employees, and any contract staff. We will attempt to maintain an accurate record of coordinator information and an estimated quantity needed for each of our facilities that will serve as a Point of Dispensing (POD) and provide that information to the local public health authorities where those facilities are located. We understand that completing this enrollment form is not a binding contract.

Organization and Coordinator Information

Name of Organization: ______________________________

Street Address: ______________________________

PO Box: ______________________________

City: ____________ State: ________ Zip code: ____________

Email: ____________ Telephone: ____________

Fax Number: ____________

Primary Coordinator

Name: ____________ Position/Title: ____________

Work Phone: ____________ Home Phone: ____________

Email: ____________ Cell/Pager: ____________

First Backup Coordinator

Name: ____________ Position/Title: ____________

Work Phone: ____________ Home Phone: ____________

Email: ____________ Cell/Pager: ____________

Second Backup Coordinator

Name: ____________ Position/Title: ____________

Work Phone: ____________ Home Phone: ____________

Email: ____________ Cell/Pager: ____________

Please provide a brief description of your service:

Estimated Numbers of Employees/Family Members/Contract Staff

Please provide information below about the population that your organization will want covered under this provider enrollment form.

Total Number of Employees:	
* Total Number of Family Members of Employees:	
Total Number of Contract Staff:	
Total number of residents/patients:	

Total Population to be Served

**To estimate the number of family members, multiply the number of employees by 2.5 (average number of persons per household).*

Of the total above, please estimate the breakdown into the following age groups when possible:

Older Adults *(age 65+)*	**Adults** *(Ages 18-64 and children over 80lbs)*	**Children** *(Under 18 and weigh less than 80lbs)*

In the event of an emergency, disease and medication information forms will be provided when you pick up the medication. You will need to copy and provide them with the medication to your clients. If you need these to be in any language other than English, please specify below. Translated forms will be provided whenever possible.

1. ______________________ 2. ______________________ 3. ______________________

4. ______________________ 5. ______________________ 6. ______________________

Additional Information and Private Industry POD Partner Enrollment Agreement

As a POD Partner, I 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. I understand that my organization or business may decline to participate in this program at any time.

I understand the primary planning assumptions of this agreement are;

1. An aerosolized Anthrax attack 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 have been relaxed to allow for the implementation of the non-medical dispensing modality.

I understand that this agreement can be used to address other types of public health emergencies if mutually agreed upon between our organization and the local/state public health authorities.

I agree to the following conditions, on behalf of myself and my organization:

1) We agree to provide the local public health authorities where we have facilities that will be serving as POD sites with the number of employees, employee family members, and contract staff to receive medication; this information will be updated as information changes.

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 for their employees, the family members of their employees, and their contract staff 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 two forms of identification at the time of pick up; an identification card issued by our organization, and a state issued ID card.

5) The representative(s) will sign for all medications and supplies received.

6) Our organization will notify the local health public 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 upon request.

8) Our organization will be responsible for returning any unopened bottles of medication to the local public health authorities where we received the medications at the beginning of the emergency.

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) For the purpose of State and/or Federal Laws and regulations, our organization will maintain and make available all records to the local public health authorities, the Georgia Department of Public Health, the US Department of Health and Human Services, and/or their assignees or agents.

11) A local public health authority may terminate this agreement for any of our facilities located within their jurisdiction should we fail to comply with these requirements. Our organization may terminate this agreement at any time at our discretion.

Authorization by our organization or business representative to become a Private Industry POD Partner:

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

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

1. FAX:
2. Mail:
3. Scan the signed form and e-mail to:

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

Thank you for enrolling to become a POD Partner!