Closed Point of Dispensing (POD) Partner Registration Form

**Yes,** we want to register with the intent to participate as a Closed POD Partner! We are interested in partnering with Crawford County Public Health for dispensing medications to our employees, their families, and/or our clients in the event of a large-scale infectious disease emergency.

Required Memorandum of Understanding with Crawford County Public Health signed:

Yes No

***Organization Information***

Name of Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | *Name* | *Title* | *Daytime phone* | *Evening/week-end home phone/ cell phone/pager* | *Email* |
| Contact Person: |  |  |  |  |  |
| Secondary Contact Person |  |  |  |  |  |
| Tertiary Contact Person |  |  |  |  |  |
| Medical personnel |  |  |  |  |  |

**Type of Organization**

Private Industry  Faith Based Organization Community Based Organization

Higher Education Government Agency (If yes, then:Local Federal) Other

***Vaccination Closed POD vs. Medication Closed POD***

A **Vaccination** POD would require everyone to **come in person** to receive a vaccination. A **Medication** POD would allow head of household to **pick up** to 20 medication doses for his/herself and family members. The exact definition of a family member is up to you to decide. Definitions might include anyone claiming residence at the employee’s household, those individuals identified as dependents on the employee’s tax forms or insurance coverage, or an employee plus a specified number (one, three, five, etc.) of other individuals such as homebound neighbors or relatives.

You can choose if you would like to operate as a Medication POD only or as both a Medication POD and a Vaccination POD. Keep in mind if you decide not to operate as a Vaccination POD, employees will have to go to Public POD sites throughout the county and it could interfere with attendance.

We plan on operating as a Medication POD only

We plan on operating as both a Medication POD and a Vaccination POD

|  |  |
| --- | --- |
| Medication POD | Vaccination POD |
| We plan on dispensing solely to  employees  We plan on dispensing to employees  and their families  We plan on dispensing to employees,  families and our clients / residents | We plan on dispensing solely to  employees  We plan on dispensing to employees  and their families  We plan on dispensing to employees,  families and our clients / residents |
|  |  |

# Employee and Client Information

# Estimated Numbers of Employees and Clients: If the number of family members is unknown Crawford County Public Health will multiply the number of employees and/or clients by 4 to get an estimate of how much medication you will need for your organization.

|  |  |
| --- | --- |
|  | *Total* |
| Employees |  |
| Employees’ Family Members |  |
| Clients |  |
| Others (i.e. Students, volunteers, and contract employees) |  |
| **Total =** | |

**Client/Services Information** (if you plan to dispense to clients)

Our clients are: *(Check as many as apply.)*

Homebound

Living in a Residential Facility (Please name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Living in a Skilled Nursing or Similar Facility (Please name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Disabled

Seniors

Clients with Specific Language Needs

Homeless

Children

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated number of clients speaking a language other than English:

What languages?

Percent of our clients that are seen on a:

Daily basis: %

Weekly basis: %

Monthly basis: %

Other *(please describe):*

Do you have a client database that is kept current? Yes No

If yes, how do you keep it current?

Brief description of the services your organization provides:

Brief summary of your day-to-day activities:

Estimated number of employees speaking a language other than English:

What languages?

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

Do you have medical/occupational health personnel on staff? Yes No

If yes (check all that apply)  MD  RN Nurse Practitioner

Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

# Communications

Check all methods you would be able to use during an emergency:

Telephone: External information line Call center/phone bank

Electronic:  Website posting Mass email message

Hard copy: Mass faxes

In Person: Meeting/Presentation Visits to clients’ homes

Other: *Please specify:*

**Receiving and Managing Inventory**

***Receiving Medications/Vaccinations***

Does this location have a loading dock? Yes No

Do you have a pallet jack or fork lift? Yes No

Person who will be authorized to receive/accept and sign for the medications/vaccinations for Closed POD site (medical personnel)

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name Title Phone*

***Managing/storing ongoing inventory***

Inventory tracking will be assigned as follows: *(check all that apply)*

One person at the organization for ongoing inventory

(Identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

One person at each Closed POD site

(Identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Staff delivering medications/vaccinations between Organization Closed POD Sites

(Identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Vaccine and medication storage available:

• POD Site refrigeration storage available for vaccines (35 to 46F/2-8C): Yes No

• Backup power for lighting and refrigeration: Yes No

• Secure POD Site Medication storage available between (59 to 86F/15-30C)

Yes No

***Confidentiality***

Individuals with access to the records and information systems (PCs, network, internet, e-mail, telephones, pagers, fax machines, etc.) of the your organization for the purpose of emergency planning and response have a legal and ethical responsibility to protect the confidentiality of personal, medical, financial, personnel, and protected health information, and to use that information and those systems only in the performance of their jobs. There is a sample Oath of Confidentiality in this packet that you may modify for your business and have staff involved with a Closed POD sign.

***Number of Closed POD Sites***

How many Closed POD Sites locations do you have? \_\_\_\_\_\_\_\_

Where are these sites located?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_

C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Training and Education***

If you plan to educate your staff about the circumstances under which the Closed POD Partner Plan would be activated, please consider including the following topics:

1. The Closed POD Partner Plan would only be activated in a **MAJOR** public health or local emergency to dispense medications to the population in a very short period of time.
2. The Closed POD Partner Program is **voluntary**, even in the time of the emergency. It should not be required as an employee’s scope of work to take emergency medications dispensed at a Closed POD.
3. This **will not** be a medical clinic. Your organization is just dispensing medication /vaccinations on behalf of Crawford County Public Health for the convenience and safety of your employees, their families, and clients in a public health emergency.
4. Please let Crawford County Public Health know if you are interested in having an exercise and/or training at your location.

Training may include what defines a public health emergency that would trigger activation of a Closed POD Site for the purpose of (mass prophylaxis).

***Authorization to participate as a Closed POD Partner***

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### ***Name (please print clearly)*** ***Title***

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

***Signature Date***