Georgia Department of Public Health
District 4 Public Health

Kathleen Toomey MD, MPH, Commissioner | Brian Kemp, Governor

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Closed 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 medical countermeasures to the public, we would like to do our part to distribute 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 Distribution (POD) and provide that information to the local public health authorities where those facilities are located. **Activation of a Closed POD during an event is optional and has no determination on whether medical countermeasures will be distributed.**

Organization and Coordinator Information

Name of Organization: _____

Street Address: _____

PO Box: _____

City: _____ State: _____ Zip code: _____

Email: _____ Telephone: _____

Fax Number: _____

Primary Coordinator

Name: _____ Position/Title: _____

Cell Phone: _____ Email: _____

First Backup Coordinator

Name: _____ Position/Title: _____

Cell Phone: _____ Email: _____

Second Backup Coordinator

Name: _____ Position/Title: _____

Cell Phone: _____ Email: _____

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 3.5 (average number of persons per household).*

In the event of a public health emergency, disease and medication/vaccine information forms will be provided when you pick up the medication/vaccines. 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. _____

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 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 may be relaxed to allow for the implementation of the non-medical dispensing modality.

We agree to the following conditions:

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

Name:_____License number (optional):_____

2. We agree to provide the local public health authorities with an estimated number of our identified populations to be served.
3. Our facilities that will serve as POD sites will follow the most current guidance that is approved by the state and/or local public health authorities.
4. 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.
5. The representative(s) picking up the medications/supplies will provide two forms of identification and sign for materials received.
6. Our facilities that will be serving as POD sites will be responsible for distribution of medication/administration of the vaccine, distribution of information sheets, and collection of completed intake forms. Intake forms will be returned to the local public health authorities along with any unused medication.
7. 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.
8. Either organization may terminate this agreement at any time.

Authorization by our organization to become a Closed POD Partner:

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

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

1. **Mail**: District 4 Public Health/Emergency Preparedness Division, ATTN: MCM Planner 160 Bastille Way, Fayetteville, GA 30214
2. **Email:** Scan the signed form and e-mail to: jacqueline.stotts@dph.ga.gov

Thank you for enrolling to become a Closed POD Partner!

(Revised: 2023)