Clayton County Board of Health
Strategic National Stockpile (SNS) Program

Closed Point of Dispensing (POD) Enrollment

(Revised 2017)

Facility: _____

Address: _____
Street *City* *State* *Zip Code* *County*

Telephone: (____) _____ Fax: (____) _____

1. Primary Contact's Name: _____
Last *First*

Phone: (____) _____ E-Mail: _____

2. Alternate Contact's Name: _____
Last *First*

Phone: (____) _____ E-Mail: _____

Coordinating Physician's Name: _____
(See bullet number 2.)

To participate in the SNS Closed POD Program and receive free of cost, Federal Strategic National Stockpile antibiotics, vaccine and medical supplies through the Georgia Department Public Health, I agree to the following conditions, on behalf of myself and all parties associated with this private business, college/university, hospital, nursing home, medical office, group practice, managed care organization, community/migrant/rural clinic, other health delivery facility, detention facility, mental health facility, prison, home health agency, Faith Based Organization, , or military institution, of which I am the ***(circle one)*** CEO, COO, Business Manager, Minister, Director, physician-in-chief or equivalent, or other: _____

_____

1. I agree to provide the Clayton County Board of Health (CCBOH) with the number of employees, staff and/or clients and their family members to receive medication and/or vaccine; this information will be updated annually upon renewal of Provider Enrollment.
2. I agree to have a coordinating physician who will oversee the dispensing of medications and/or administration of vaccine. The physician does not have to be on-site, but staff will work under his/her direction.
3. The facility will follow the same treatment algorithms as used in the standing orders for the state, which will be provided at the time of operations.
4. A representative from the organization, with proper identification, will pick up medications, vaccines, and/or supplies for employees, staff and/or clients and their family members from the pre-designated Local Distribution Site (LDS) site in Clayton County.

5. The facility will be responsible for administration and tracking of the medication/vaccine, distribution of information sheets, and collection of completed health information forms. Health information forms will be returned to the CCBOH within 48 hours for patient and medication/vaccine tracking.
6. The facility agrees to make no charge for the medication/vaccine or for any of the services provided as a part of the administration of the medication/vaccine.
7. For the purpose of State and/or Federal Laws and regulations, I will:
   a. Maintain and make available all records to the Clayton County Board of Health, the Georgia Department of Public Health, U.S. Department of Health and Human Services, and/or their assignees or agents.
8. The CCBOH may terminate this agreement at any time for failure to comply with these requirements and may terminate this agreement at any time with prior notice.

Signature of Administrative Representative for Organization DATE

Printed Name:_____

Signature of Coordinating Physician DATE

Printed Name:_____

This record is to be submitted to and kept on file at the Clayton County Board of Health, Office of Emergency Preparedness and Response, and must be updated in accordance with State policy (annually).

Total number of Employees, Staff and/or Clients:	
* Total number of Family Members of Employees, Staff and/or Clients:	

To estimate the number of family members, multiply the number of employees by 3.2 (average number of persons per household).

TOTAL Number of Persons needing medication/vaccinations:_____

The Original Copy of this form will be kept on file at the CCBOH, Office of Emergency Preparedness and Response. A copy of this enrollment form will be given to the participating organization.

No information contained within this enrollment form will be shared with any third party.