Alabama Department of Public Health
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Closed POD Participation Request Packet

THIS BOX IS FOR OFFICE USE ONLY	
County Autauga	**Public Health District** East Central
Completion Date	

ENROLLMENT

I. Organization Information

Name of Organization			
☐ Private Industry/ Business	☐ Community Based Organization	☐ Health Care	
☐ Faith Based Organization	☐ Higher Education	☐ Government Agency	☐ Other
If it is a government agency, please specify whether it is local, state, or federal:			
Address			
Phone Number	Fax	FIN#	
Closed POD Site Location (Physical Address)			

II. Person responsible for signing Memorandum of Understanding (MOU)

Name	Title
Phone Number	E-Mail Address

III. Contact Information

Primary Contact Person

Name	Title
Phone Number	E-Mail Address

Secondary Contact Person

Name	Title
Phone Number	E-Mail Address

IV. Medical Personnel/Director Information

You will need to have medical personnel available who can legally dispense medications. You may have medical personnel on staff, or you may use personnel who normally dispense medication in your facility to supervise the distribution process.

Name	Phone Number
DEA#	

Reviewed by EP Director: ______________________________

SNS Coordinator: ____________________ ____________________ **Date:**________________

Approved *Denied*

State Pharmacy ____________________ ____________________ **Date:**________________

Approved *Denied*

Alabama Department of Public Health

Strategic National Stockpile (SNS) Program

Closed POD Participation Request Packet

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ENROLLMENT ACKNOWLEDGEMENT

I agree to have a coordinating physician who will oversee the dispensing of medications and/or administration of vaccines. The physician does not have to be on site, but staff will work under his/her direction.

The facility will follow the same treatment algorithms as used in the standing orders for the state.

The facility will notify ADPH when the supplies reach the facility and if there are any discrepancies between the order and delivery.

The facility will be responsible for dispensing of the medication/vaccine, distribution of information sheets, and collection of completed health information forms. Health information forms will be returned to ADPH within 48 hours from the closing of the POD. All HIPAA laws and requirements will be maintained by both parties.

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.

For the purpose of State and/or Federal Laws and regulations, I will:

A. Maintain and make available all Closed POD records to the Alabama Department of Public Health, the U.S. Department of Health and Human Services, and/or their assignees or agents;

B. Comply with Presidential Executive Order No. 12549, Certification Concerning Debarment and Suspension.

I acknowledge that I have read, understand, and agree to policies and procedures of participating in ADPH's Closed POD Program as defined in the Closed POD Participation Request Packet that I received.

I understand that by completing this form I am requesting to become a Closed POD and will not be officially considered a Closed POD until I sign and return the MOU provided by ADPH. I also acknowledge that when I receive a Closed POD MOU that it must be signed and returned to the Alabama Department of Public Health within 7 business days of the date it is received.

Name of Organization		
Phone Number	**Fax**	**FIN# or EIN#**
Name (Print)	**Title**	
Signature	**Date**	