Alabama Department of Public Health

Strategic National Stockpile (SNS) Program

Closed POD Participation Request Packet

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

WORKSHEET

Please use the following worksheet to help develop your Closed POD plan. Be sure to retain a copy of your plan for your records.

I. Organization Information

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 the language in the space provided below. Translated forms will be provided whenever possible.

Name of Organization		
Address		
Phone Number	**Fax**	**FIN#/EIN#**

II. Language

III. Estimated Total Number of People to be Served

1. Total Number of Employees	
2. Total Number of Family Members of Employees	
3. Total Number of Other Population to be Served (i.e. residents, In-house Contracted Individuals, Inmates, etc.	
Total Number of All People to be Served (Please Add Total from Rows 1-3)	

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

IV. Security

Do you have security measures in place at your facility such as security personnel, limited or controlled access, and/or video surveillance to protect the medications and control access to the site?	**YES** ☐
	NO ☐

Medications should be kept away from extreme heat or cold and stored in a secure location (a locked room or locked cabinet where few individuals have access).

V. Medication Tracking (REQUIRED)

Is the provider capable of tracking medication distributed to employees and family members using the following THREE guidelines? A. Number of employees who picked-up medication B. Total number of medications picked-up by head of household (or total number of vaccinations administered per household) C. Number and name of antibiotic	**YES** ☐ **NO** ☐
Is the provider capable of reporting any life-threatening and/or serious adverse events to the appropriate agent (i.e., VAERS, MedWatch)?	**YES** ☐ **NO** ☐

In addition to tracking medication, employees will be REQUIRED to complete an intake assessment form before receiving medication/vaccine and be screened for contraindications.

VI. Event Education

Will your organization provide pre-event education to employees for your dispensing plans (via online training, drills, handouts, or any other method)?	**YES** ☐ **NO** ☐
What method does your facility plan to use?	
What method will be used to keep provider and staff informed about the emergency? (i.e., changes to the treatment, response, etc.) _____ _____	

VII. Supplies

Do you have supplies and equipment already on-site?	**Y** ☐	**N** ☐
Would additional items need to be stockpiled?	**Y** ☐	**N** ☐
If yes, please comment addition items that may be needed: _____ _____ _____ _____		

VIII. Vaccine Storage/Handling

Does your facility have any of the following vaccine storge capability? A. Ultra-Cold (-70°C ± 10°C) freezer ☐ B. Non-Ultra Cold Freezer ☐ C. Stable Refrigeration ☐ D. None (If you answered no, do not complete this portion of the worksheet) ☐ If yes, please list storage unit details: _____ _____ _____		
Does your facility have on-site temperature monitoring devices (and backups) to constantly monitor vaccine temperatures?	**Y** ☐	**N** ☐
Is your POD Medical Officer/Vaccine Coordinator currently enrolled in ImmPRINT as a vaccine provider?	**Y** ☐	**N** ☐
Does your facility have a plan for obtaining back-up cold chain management equipment? (Portable insulated containers, refrigerators, data loggers, dry ice vendors, etc.)	**Y** ☐	**N** ☐

It is a requirement to use ImmPRINT and enter vaccine data within 24 hours of administration. In addition to tracking medication, employees will be REQUIRED to complete an intake assessment form before receiving medication/vaccine and be screened for contraindications.

Primary Vaccine Coordinator (Medical Officer)

Name	Phone Number
Email	License #

Back-up Vaccine Coordinator

Name	Phone Number
Email	License #

_____

_____ _____

Name (Print) **Title**

_____ _____

Signature **Date**