



**North Central Health District  
Medical Countermeasure (MCM) Program**

**Closed Point of Distribution Site Enrollment Form**

<input type="checkbox"/> Initial Enrollment	Date: _____	<input type="checkbox"/> Renewal	Date: _____
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Facility: \_\_\_\_\_

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

Telephone: (\_\_\_\_\_) \_\_\_\_\_  
Street City State Zip Code County

Fax: (\_\_\_\_\_) \_\_\_\_\_

**Facility information: (Please circle)**

-Direct delivery-yes no

-Loading dock-yes no

-Would the facility be willing to conduct mass vaccinations? yes no

-Would your site be capable of using a drive thru model of distribution? yes no

-What medical grade cold storage does the facility have? refrigerator freezer ultracold none

1. Facility Contact's Name (primary): \_\_\_\_\_  
Last First

Phone: (\_\_\_\_\_) \_\_\_\_\_ After Hours Phone: (\_\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_

2. Facility Contact's Name (secondary): \_\_\_\_\_  
Last First

Phone: (\_\_\_\_\_) \_\_\_\_\_ After Hours Phone: (\_\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Medical License #: \_\_\_\_\_

By completing this form, your agency is enrolling to be a closed Point of Distribution (POD) site. A closed distribution site (also known as a closed point of distribution or closed POD) is an agency that is able and agrees to distribute medication or administer vaccine to its employees, employees' families, patients, students, and/or inmates in the event of a public health emergency that requires the release of Federal Medical Countermeasure medication or vaccines from the Strategic National Stockpile or elsewhere. Examples of the types of entities that register as a closed POD site: a health care facility, mental health facility, business, college, detention center, prison, military institution, etc.

To participate in the MCM Closed POD Site program and receive free, emergency specific Medical Countermeasures like antibiotics, vaccine, and/or medical supplies through the Department of Public Health, I agree to the following conditions:

1. I am the (circle one or write-in) CEO, Business Manager, physician-in-chief or equivalent, president, Commander or other: \_\_\_\_\_, and I have the authority to register on behalf of myself and all the practitioners, nurses, and others associated with this health care facility, mental health facility, business, college, detention center, prison, or military institution.
2. I agree to provide the North Central Health District (NCHD) with the number of employees, employees' family members, and clients to receive medication and/or vaccine; this information will be updated regularly to ensure the most up-to-date information by the County Health Department CHEART leader or designee, a member of the NCHD EP staff, or by the Closed POD Coordinator.

3. I agree to have a coordinating physician who will oversee the distribution of medications and/or administration of vaccine. The physician does not have to be on-site, but staff will work under his/her direction.
4. The facility will follow the same treatment algorithms as used in the standing orders for the state.
5. A representative from the facility, with proper identification, will pick up medications, vaccines, and/or supplies from the designated location (location will be determined at the time of the event). The facility will provide NCHD with the name of the representative designated to pick up medications and/or vaccine prior to pick up.
6. Upon arrival to the designated pick-up location, the representative will present two personal ID's, one issued by the facility, and a picture ID issued by the state.
7. The representative will sign for all medications, vaccines and/or supplies received.
8. The facility will be responsible for administration of the medication/vaccine, distribution of information sheets, and collection of completed patient information forms. Patient information forms will be returned to NCHD within 48 hours for patient tracking.
9. The facility will not charge for the medication/vaccine. Additionally, the facility will not charge for any of the services provided as a part of the administration of the medication/vaccine, unless DPH specifies allowable administration costs.
10. The facility will return all unused portions of the supplies to the North Central Health District with documentation showing they have been maintained properly.
11. For the purpose of State and/or Federal Laws and regulations, I will maintain and make available all records to the North Central Health District, Georgia Department of Public Health, Centers for Disease Control and Prevention, the U.S. Department of Health and Human Services, and/or their assignees or agents.
12. I may withdraw my facility from the MCM Closed POD Site program at any time for any reason by contacting the North Central Health District, Office of Emergency Preparedness. I understand that participation in the MCM Closed POD Site program is contingent upon complying with the conditions outlined above.

Number of Employees, Family members, patients/students/inmates (as applicable):

# of staff/employees/faculty \_\_\_\_\_  
 # of staff/employee/faculty family members (staff # X 3.5) \_\_\_\_\_  
 # patients/students/inmates (circle one) \_\_\_\_\_  
 # other group: \_\_\_\_\_

**TOTAL Number of Persons needing medication/vaccinations** \_\_\_\_\_

This form is to be submitted to and kept on file at the North Central Health District, Office of Emergency Preparedness, and must be updated in accordance with State policy.

Original Copy to be kept on file at:

North Central Health District, Office of Emergency Preparedness

Copy to be sent to \_\_\_\_\_ County Health Department

Copy will be scanned into the KNACK database for the MCM Program Office

Copy to be given to Facility

For more information on this Enrollment Form or Becoming a Closed POD Site, contact:

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 Office of Emergency Preparedness  
 201 Second St., Suite 1100  
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 478-972-0465 (mobile)  
 478-751-4575 (FAX)  
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