Macomb County Health Department
Closed POD Partner Registration Form

Yes, we want to register with the intent to participate as a Closed POD Partner! We are interested in partnering with the Macomb County Health Department for dispensing medications to our employees, their families, and/or our clients in the event of a large-scale infectious disease emergency.

Organization Information

Name of Organization **Phone Number**

Address

Primary Contact Person:

Name Title

Office Phone Number Cell Phone Number Email Address

Secondary Contact Person:

Name Title

Office Phone Number Cell Phone Number Email Address

Tertiary Contact Person:

Name Title

Office Phone Number Cell Phone Number Email Address

Type of Organization:

☐ Private Industry ☐ Faith Based Organization ☐ Community Based Organization
☐ Higher Education ☐ Government Agency (If yes, then: ☐ Local ☐ Federal) ☐ Other

Employee and Client Information

Estimated Numbers of Employees and Clients: If the number of family members is unknown multiply the number of employees and/or clients by 4 to get an estimate of how much medication you will need for your organization.

	Number of Adults	**Estimated Number of Children under age 18**
Employees, volunteers & contractors		
Employees' Family Members		
Clients		

☐ We plan on dispensing solely to employees
☐ We plan on dispensing to employees and their families
☐ We plan on dispensing to employees, families and our clients

Client/Services Information: (if you plan to dispense to clients)
Our clients are: *(Check as many as apply.)*

☐ Homebound
☐ Living in a Residential Facility (Please name: _____)
☐ Living in a Skilled Nursing or Similar Facility (Please name: _____)
☐ Disabled
☐ Seniors
☐ Clients with Specific Language Needs
☐ Homeless
☐ Children
☐ Other: _____

Would you need information in any other language other than English? If so, please tell us the estimated number of staff or clients speaking a language other than English: _____

What languages? _____

Percent of our clients that are seen on a:

Daily basis: _____%
Weekly basis: _____%
Monthly basis: _____%
Other *(please describe):* _____

Do you have a client database that is kept current? ☐ No ☐ Yes
If yes, how do you keep it current?

Brief description of the services your organization provides:

Brief summary of your day-to-day activities:

Do you have medical/occupational health personnel on staff? ☐ Yes ☐ No

If yes (check all that apply) ☐ MD ☐ RN ☐ Nurse Practitioner

☐ Other (please specify): _____

Communications

Check all methods you would be able to use during an emergency:

Telephone:	☐ External information line	☐ Call center/phone bank
Electronic:	☐ Website posting	☐ Mass email message
Hard copy:	☐ Mass faxes	
In Person:	☐ Meeting/Presentation	☐ Visits to clients' homes
	☐ Other, *Please Specify:* _____	

Notification

Please give a brief description of how you would notify your staff and/or clients of an emergency (i.e. mass email, mass texting, electronic call out system, hotline).

Receiving and Managing Inventory

Receiving antibiotics:

Person who will be authorized to receive/accept and sign for the antibiotics:

Closed POD Coordinator ☐

Other ☐ *Please Specify:* _____

Managing ongoing inventory:

Inventory tracking will be assigned as follows: *(check all that apply)*

☐ One person at the organization for ongoing inventory

(Identify: _____)

☐ One person at each dispensing site

(Identify: _____)

☐ Dispensers who are delivering antibiotics to another location, etc.

(Identify: _____)

Other

How many site locations do you have? _____

Where are these sites located?

A) _____

B) _____

C) _____

Public Dispensing (Optional)

Would you be interested in opening your site to serve the public? ☐Yes ☐No ☐Unsure

Training and Education

If you plan to educate your staff about Closed POD Operations, consider including the following topics:

a) The Closed POD Plan would only be activated in a MAJOR public health or local emergency to dispense medications to the population in a very short period of time.
b) The Closed POD Program is voluntary, even in the time of the emergency. It should not be required as an employee's scope of work to take emergency medications dispensed at a Closed POD.
c) This will not be a medical clinic. Your organization is just dispensing medication on behalf of your local health department for the convenience and safety of your employees and their families in a public health emergency.

Please let your local health department know if you are interested in having an exercise and/or training at your location or if you are interested in attending an exercise and/or training at another location. Most exercises or trainings take about 2-3 hours.

Authorization by (name of Director or Organization Representative) to participate as a Closed POD Partner

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

Please return your completed form to

April Walton, MA, PEM
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Mount Clemens, MI. 48043
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