Florida Department of Health
Closed Point of Dispensing (POD) Registration Form

☐ **Yes, we want to participate in the Closed POD Program**

In the event of a public health emergency that would require distribution and dispensing of medications to the public, we would like to dispense these medications to our employees, families, and/or clients, if applicable. We will identify coordinators within our organization, estimate the quantity of medications needed, and keep this information current with our local Department of Health. We understand that participation in this program is voluntary and this enrollment form is not legally binding.

Date: _____

Organization Name: _____

Street address: _____

City: _____ State: _____ ZIP Code: _____

Mailing address (if different): _____

City: _____ State: _____ ZIP Code: _____

Main phone number: _____ (Please provide a main switchboard or front office number)

Website: _____

Would you be willing to pick up medications for other registered organizations in your geographic area?

(Organizations on your street, in your office building, etc.) ☐ Yes ☐ No

Estimated population to be covered: _____

Notes:

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To participate in the Closed POD Program and receive medication and supplies free of cost from the Florida Department of Health (DOH), I agree to the following conditions and understand that reimbursement for expenses incurred in participation in this program may not be available. I also understand that this registration will be renewed every 3 (three) years and either party may terminate their participation at any time.

Prior to an emergency, I agree that my organization will:

- Update contact information or estimated number of doses needed at least annually or as the information changes
- Maintain plans to dispense medications including having access to a licensed medical professional (whether on-site or available by phone)

During an emergency, I agree that my organization will:

- Follow the algorithm provided by DOH for dispensing medications
- Provide the local county health department with the name of the representative who will be picking up the materials. This person must arrive at the pre-designated site with two forms of identification and must sign-off on receipt of the medication and/or supplies to be distributed.
- Notify the county health department when the supplies reach the facility and of any discrepancies between order and delivery
- Be responsible for dispensing of the medication(s), distributing the information sheets, and collecting the patient information sheets which must be returned to the local county health department within 48 hours for tracking purposes
- Return any unused medication and supplies to the local county health department
- Agree to make no charge for the medication or supplies
- Agree to submit all DOH and/or Centers for Disease Control and Prevention (CDC) required forms to the local county health department

As an authorized official of the abovenamed organization, I agree to these conditions.	
Signature:	
Printed name:	**Date:**

For DOH/CHD Use Only	
Received date:	
Received by:	

Agency Name:

Primary Coordinator	
Name	
Position/Title	
Office Phone	
Cell Phone	
Email	

Secondary Coordinator	
Name	
Position/Title	
Office Phone	
Cell Phone	
Email	

Tertiary Coordinator	
Name	
Position/Title	
Office Phone	
Cell Phone	
Email	

After-hours contact	
Name	
Position/Title	
Phone	