MISSISSIPPI STATE DEPARTMENT OF HEALTH

Strategic National Stockpile (SNS) / Pandemic Influenza Program Provider Enrollment

□ Initial Enrollment □ Renewal

Facility Name_____

Type of Facility _____ County_____

Physical address _____
Street *City* *State* *Zip Code*

Mailing address _____
(If different from above) *Street / P.O.Box* *City* *State* *Zip Code*

Telephone (_____)_____ Fax (_____)_____

1. Primary 24-hour Facility Contact Name _____
Last *First* *Title*

Primary 24-hour Phone _____E-Mail _____

2. Secondary 24-hour Facility Contact Name _____
Last *First* *Title*

Secondary 24-hour Phone _____E-Mail _____

 # Staff /Employees /Faculty /Students 1. _____

 # Family members = Line 1 multiplied by 3 2. _____

 # Patient beds 3. _____

TOTAL number of persons needing medications/vaccinations _____

Facility has capacity to, and assumes responsibility for, the administering of vaccine to facility's entire CPOD population: **YES □**

NO □

To participate in the SNS/Pandemic Influenza Program and receive, free of cost, Federal Strategic National Stockpile antibiotics, vaccine and medical supplies through the Mississippi State Department of Health, I agree to the conditions below, on behalf of myself and all the practitioners, nurses, pharmacists, and others associated with this: healthcare facility, academic institution, correctional facility, military installation, community/faith based facility, government agency, or private business.

1. I agree to provide the MSDH with the number of staff and clients to receive medication and/or vaccine; this information will be updated annually upon renewal of Provider Enrollment.
2. I agree to have a medical consultant (physician or pharmacist) who will oversee the dispensing of medications and/or administration of vaccine. The medical consultant does not have to be on-site, but staff will work under his/her direction.
3. The facility will follow the same treatment algorithms as used in the standing orders for the state.
4. A representative from the facility, with proper identification, will pick up medications, vaccines, and/or supplies for clients and staff from the pre-designated Point-of-Dispensing (POD) site. The facility will provide MSDH with the name of the representative designated to pick up medications and/or vaccine prior to pick up.
5. Upon arrival to the designated POD site, the representative will present two personal ID's, one issued by the facility, and a picture ID issued by the state.
6. The representative will sign for all medications, vaccines and/or supplies received.
7. The facility will notify MSDH when the supplies reach the facility, also if there are discrepancies between the order and delivery.
8. The facility will be responsible for administration of the medication/vaccine, distribution of information sheets, and collection of completed health information forms. Health Information Forms will be returned to MSDH within 48 hours for patient tracking.
9. 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.
10. I understand if a vaccine is required and the Closed POD facility does not have the capability to administer injections to the entire CPOD population, they must to go to an Open POD site for vaccination.
11. Upon conclusion of event, facility agrees to follow MSDH guidance to return all unused, unopened medications, vaccines and/or supplies and completed CPOD Inventory Final Summary Form.
12. For the purpose of State and/or Federal Laws and regulations, I will:
    a. Maintain and make available all records to the Mississippi State Department of 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.
13. The State may terminate this agreement at any time for failure to comply with these requirements and I may terminate this agreement at any time for personal reasons.

_____

Signature of Administrative Representative for Facility Title Date

_____

Signature of Medical Consultant Print Name Date

_____

Medical Consultant Title Medical Consultant License #

☐ *Check if Medical Consultant is a physician or pharmacist **NOT** affiliated with Closed POD facility.*

(For facilities over 5,000 regimens /or special circumstances deemed necessary by MSDH)

Facility Ship to Address _____

Exact Location on Facility Campus for Drop Ship_____

For Official Use Only:

Facility GPS Coordinates	MSDH Staff Reviewing Application
_____(Ex. 00.000000) Latitude _____(Ex. -00.000000) Longitude ***Region:*** *Please include GPS Coordinates for all Direct Ships*	_____ Print _____ Signature Date _____ Date entered on CPOD spreadsheet

- **Original Enrollment Form to be kept on file at the MSDH Regional Office by Regional Emergency Preparedness Nurse and will be updated as necessary.**
- **Copy to be sent to SNS Program at MSDH Central Office.**
- **Copy to be given to CPOD Facility.**