Region IV Public Health Push Partner Registry Enrollment Form

☒Yes, we want to participate in the Region IV Public Health Push Partner Registry!

In the event of a large-scale public health emergency that would require distribution of medications or vaccines to the public, we would like to do our part to **dispense/vaccinate** our employees (and possibly their families) and clients, if applicable. We will attempt to maintain an accurate record of coordinator information and estimated quantity of employees, employee family members and number of clients or residents for our organization with the local public health authority. We understand that completing this enrollment form is not a binding contract.

Organization and Coordinator Information

Name of Organization: ______________________________

Name of Occupational Health or Safety Director (responsible for function) ______________________________

Street Address: ______________________________

PO Box: ______________________________

City: ____________________ State: ______ Zip: __________

Email: ____________________ Telephone: ____________________

Fax Number: ______________ Mobile Telephone: ____________________

Push Partner Dispensing or Vaccination Primary Coordinator

Name: ____________________ Position/Title: ____________________

Work Phone: ____________________ Home Phone: ____________________

Email: ____________________ Cell/Pager: ____________________

First Backup Coordinator

Name: ____________________ Position/Title: ____________________

Work Phone: ____________________ Home Phone: ____________________

Email: ____________________ Cell/Pager: ____________________

Second Backup Coordinator

Name: ____________________ Position/Title: ____________________

Work Phone: ____________________ Home Phone: ____________________

Email: ____________________ Cell/Pager: ____________________

Public Health
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Region IV Public Health
Clark, Cowlitz, Skamania, Wahkiakum counties and Cowlitz Tribe

Please provide a brief description of your services: ____________________

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Estimated Numbers of Employees and Clients/Residents/Population

Please provide information about your organization at full capacity.

Employees: ____________________

Family Members of Employees*: ____________________

Clients/Residents Served**: ____________________

TOTAL [Employees + Family Members + Clients (if applicable)]: ____________________

* Estimates of family members can be calculated by multiplying the number of employees by **2.5-3.0** (average number of persons per household). ** Applicable to residential or vulnerable populations service providers only

Of the total above, please estimate the breakdown into the following age groups:

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

In the event of an emergency, disease, **medication/vaccination** information forms will be provided when you pick up the **medications/vaccinations**. You will need to copy and provide them with the medication/vaccination to your clients. If you need these to be in any language other than English, please specify below. Translated forms will be provided whenever possible.

1. ____________ 2. ____________ 3. ____________

Push Partner Registry Agreement

To participate in the Region IV Public Health Push Partner Registry Program and receive, free of cost, Federal Strategic National Stockpile **antibiotics or vaccines** and medical supplies from the local public health authority and/or the Washington State Department of Health, I agree to the following conditions, on behalf of myself and all the practitioners associated with this hospital, nursing home, medical office, group practice, community/migrant/rural clinic or other health delivery facility, fire department, emergency medical services, detention facility, mental health facility, home health agency, community based organization or business of which I am the **(Please Circle): CEO, Business Manager, Minister, physician-in-chief, Administrator, Executive Director, or equivalent**.

1. I agree to provide the local public health authority with the number of employees, family members, and clients to receive **medication/vaccination**; this information will be updated as information changes.
2. I agree to have a coordinating licensed medical professional who will oversee the dispensing of **medications or vaccinations**. The licensed medical professional does not need to be on-site (for example, dispensing to homebound clientele), but **dispensing/vaccination** staff will work under his/her direction and comply with local medical practice laws and emergency use authorizations. In the absence of a licensed medical professional, I agree to defer medical/medication questions to the Region IV Public Health helpline, in addition to referring persons to their medical provider, where necessary.
3. The organization/ facility will follow the same treatment algorithms as used in the standing orders provided by the local public health authority.
4. A representative from the organization/ facility, with proper identification, will pick up **medications/vaccinations** and supplies for clients and staff from the pre-designated pick up site. The organization/ facility will provide the local public health authority with the name of the representative to pick up medications prior to pick up.
5. The organization representative will sign for all **medications/vaccination** and supplies received.
6. The organization/ facility will notify the local health public authority when the supplies reach their facility and if there are any discrepancies between the order and delivery.
7. The organization/ facility will be responsible for administration of the **medication/vaccination**, distribution of information sheets, and collection of completed intake forms. Intake forms will be returned to the local public health authority within 48-72 hours for patient tracking.
8. The organization/ facility will be responsible for returning any unopened bottles of **medication/vaccination** to the local public health authority unless other arrangements have been made.
9. The facility agrees to make no charge for **the medication/ vaccination** or for any of the services provided as a part of the administration of the **medication/vaccination**.
10. For the purpose of State and/or Federal Laws and regulations, I will maintain and make available all records to the local public health authority or Washington State Department of Health, the U.S. Department of Health and Human Services, and/or their assignees or agents.
11. The local public health authority may terminate this agreement at any time for failure to comply with these requirements.
12. I, as an official representative of my organization, may terminate this agreement at any time at my discretion upon notifying the local public health authority.

Authorization by CEO, Business Manager, Minister, physician-in-chief, Administrator, Executive Director or equivalent to Participate as a Push Partner

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

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You may return the form in any three ways:

1. Mail: Lianne Martinez, Clark County Public Health, PO Box 9825, Vancouver, WA 98666-8825
2. E-Mail: Scan the signed form and e-mail to: Lianne.Martinez@clark.wa.gov

Please return the original and save a copy to complete various sections of your Dispensing Plan.

Thank you for enrolling to become a Push Partner!