Alabama Department of Public Health
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Closed POD Participation Request Packet

THIS BOX IS FOR OFFICE USE ONLY	
County	**Public Health District**
Completion Date	

ENROLLMENT

I. Organization Information

Name of Organization		
☐ Private Industry/ Business ☐ Community Based Organization ☐ Health Care ☐ Faith Based Organization ☐ Higher Education ☐ Government Agency ☐ Other		
If it is a government agency, please specify whether it is local, state, or federal:		
Address		
Phone Number	Fax	FIN#
Closed POD Site Location (Physical Address)		

II. Person responsible for signing Memorandum of Understanding (MOU)

Name	Title
Phone Number	E-Mail Address

III. Contact Information

Primary Contact Person

Name	Title
Phone Number	E-Mail Address

Secondary Contact Person

Name	Title
Phone Number	E-Mail Address

IV. Medical Personnel/Director Information

You will need to have medical personnel available who can legally dispense medications. You may have medical personnel on staff, or you may use personnel who normally dispense medication in your facility to supervise the distribution process.

Name	Phone Number
DEA#	

Reviewed by EP Director: ____

SNS Coordinator: ____________________ ____________________ **Date:**________________

Approved *Denied*

State Pharmacy ____________________ ____________________ **Date:**________________

Approved *Denied*