QVHD Push Partner Agreement

☐ Yes, we want to participate in the Push Partner program!

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

Organization and Coordinator Information

Name of Organization: ______________________________

Street Address: ______________________________

PO Box: ______________________________

City: ____________________ State: ______ Zip: __________

Email: ____________________ Telephone: ____________________

Fax Number: ______________ Tax ID # (optional): ____________________

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: ____________________

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*: ______________________

Students/Residents Served: ______________________

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

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Estimates of family members can be calculated by multiplying the number of employees and clients by* **2.5 *(average number of persons per household).*

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 and medication information forms will be provided when you pick up the medication. You will need to copy and provide them with the medication 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. ______________

4. ______________ 5. ______________ 6. ______________

Additional Information and Push Partner program agreement

To participate in the Push Partner program and receive, free of cost, Federal Strategic National Stockpile (SNS) medications and medical supplies through QVHD, I agree to the following conditions of participation on behalf of the above named facility/agency/institution.

1. I agree to provide QVHD with the number of employees, family members, and clients to receive medication; this information will be updated annually, or as information changes.
2. I agree to have a coordinating licensed medical professional who will oversee the dispensing of medications. The licensed medical professional does not need to be on-site (for example, dispensing to homebound clientele), but dispensing staff will work under his/her discretion.
3. The facility will follow the same treatment algorithms as used in the standing orders for the state and/or QVHD.
4. A representative from the facility, with proper identification, will pick up medications and supplies a pre-designated pick up site. The facility will provide the QVHD with the name of the representative to pick up medications prior to pick up.

5. The representative will sign for all medications and supplies received.
6. The facility will notify the local health public authority when the supplies reach the facility and if there are any discrepancies between the order and delivery.
7. The facility will be responsible for administration of the medication, distribution of information sheets, and collection of completed intake forms. Intake forms will be returned to QVHD within 48 hours for patient tracking.
8. The facility will be responsible for returning any unused medication to QVHD.

9. The facility agrees to make no charge for the medication or for any of the services provided as a part of the administration of the medication.
10. For the purpose of State and/or Federal Laws and regulations, I will maintain and make available all records to the QVHD or the Connecticut Department of Public Health, the U.S. Department of Health and Human Services, and/or their assignees or agents.
11. The QVHD may terminate this agreement at any time for failure to comply with these requirements and I may terminate this agreement at any time at my discretion.

Authorization to Participate as a Push Partner

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

You may return the form:

1. Fax to *203-2484528*, Attn: *Leslie Balch*
2. Mail to *lbalch@qvhd.org*
3. Scan the signed form and email to *lbalch@qvhd.org*

Thank you for choosing to become a Push Partner!