PUSH PARTNER REGISTRY ENROLLMENT FORM

To complete the form online please visit www.CRINorthwest.org

☒ Yes, we want to participate in the Push Partner Registry!

In the event of a large-scale public health emergency that would requires distribution of medications to the public, we would like to dispense these medications to our employees and clients, if applicable. We will identify organizational coordinators and estimate the quantity of medications needed, and keep this information current with the local public health authority. We understand that participation in this program is voluntary and this enrollment form is not a binding contract, and does not make us an agent of the county.

Organization Information

Name of Organization: _____

Street Address: _____

PO Box: _____ **Website** _____

City: _____ **State:** _____ **Zip:** _____

Main Telephone*: _____ **Fax:** _____

* If possible, please provide a main switchboard or front office number rather than one of the 3 contact numbers.

Are you authorized by the State of Oregon or Washington to administer vaccine? ☐ YES ☐ NO

Please select all that describe your organization: ☐ long term care facility ☐ first responder

☐ large public employer ☐ large private employer ☐ critical infrastructure ☐ hospital/clinic

☐ "at risk" or "vulnerable population" service provider ☐ other: _____

In an emergency, would you pick up medication for other organizations in your geographic location? Ex. other organizations on your street, or in your building? ☐ YES ☐ NO

If yes, please document which additional organizations you will assist and provide the total number of recipients. (Use additional pages if necessary) _____

Disease and medication information forms will be provided by email or when you pick up the medication. You will need to make copies and provide the information with the medication. 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. _____

Required Information	
Number of Employees	
Multiply by average household size for your organization*	X 3
Staff/Family Total	
Example: 100 employees X 3 = 300 total people.	

*Standard Household size (3 people) is calculated based on 2010 US Census data. This number may be altered to better fit your organization's families upon documented request.

Complete ONLY if you plan to dispense to clients under your organizations' care	
Total clients Please use "at capacity" number	
Do you serve children or adults under 80 lbs?	☐**YES** ☐**NO**
Approximately what percentage is this of the client base	_____**%**
Do you serve a large number of pregnant women?	☐**YES** ☐**NO**
Approximately what percentage is this of the client base	_____**%**

Coordinator Information

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: _____

To participate in the Push Partner Registry Program and receive medication and medical supplies free of cost from the local public health authority (LPHA) and/or the Oregon Health Authority (OHA),I agree to the following conditions and understand reimbursement for expenses incurred in participation with this program may not be available. LPHA may terminate this agreement at any time and I may terminate this agreement at any time at my discretion.

Prior to an emergency I agree to:

1. Provide the LPHA with the number of employees, family members, and clients to receive medication; I will update this information annually or as information changes.
2. Maintain a plan for having 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 direction.

During an emergency, I agree that my organization will:

3. Follow the same treatment algorithms as used in the standing orders for the state and/or LPHA.
4. Send a representative, with proper identification to the pre-designated pick up site. The representative will pick up, and sign for, medications and supplies to be distributed.
5. Provide the LPHA with the name of the representative to pick up medications prior to pick up.
6. Notify LPHA when the supplies reach the facility and of any discrepancies between the order and delivery.
7. Be responsible for administration of the medication, distribution of information sheets, and collection of completed intake forms. Intake forms will be returned to the LPHA within 48 hours for patient tracking.
8. Be responsible for returning any unopened bottles of medication to the LPHA.
9. Agree 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, maintain and make available all records to the LPHA and/or OHA.

Authorized Signature

I sign on behalf of myself and all the practitioners, nurses and others associated with this organization of which I am the authorized official.

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

You may return the form in any one of these ways:

1. Fax to 503-988-3407, attn: Melissa McKinney
2. Mail to 426 SW Stark Street, 3rd Floor, Portland, OR 97204, Attn: Melissa McKinney
3. Enrollment completed on line can be emailed to: melissa.mckinney@multco.us