Florida Department of Health
Closed POD Contact Information Sheet

Date: ___________________

Organization Name: ____

Street address: ____

City: ________________________________ State: _________________ ZIP Code: ______________

Mailing address (if different): ____

City: ________________________________ State: _________________ ZIP Code: ______________

Main phone number: ______________________________ (Please provide a main switchboard or front office number)

Website: ____

Registered in FL SHOTS?________ Name in SHOTS:_______________________ PIN:_____________

Estimated number of staff:_____________ Estimated number of clients, if applicable:______________

Partner type:

☐ Hospital ☐ Health care facility ☐ Business ☐ Tribal nation ☐ Fire department ☐ EMS

☐ Law enforcement ☐ Retail pharmacy ☐ Military installation ☐ City/county government agency

☐ State government agency ☐ Federal government agency

☐ Other, please specify: ____

Does your organization employ or have access to any of the following health care professionals?
(Select all that apply)

☐ Pharmacist ☐ Doctor ☐ Physician assistant/APRN ☐ Nurse ☐ Paramedic

☐ Other, please specify: _________________________________

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Partner Name:	
Primary Contact	
Name	
Position/Title	
Office Phone	
Cell Phone	
Email	

Secondary Contact	
Name	
Position/Title	
Office Phone	
Cell Phone	
Email	

Tertiary Contact	
Name	
Position/Title	
Office Phone	
Cell Phone	
Email	

After-hours (24/7) Contact	
Name	
Position/Title	
Phone	

For DOH/CHD Use Only	
Received by:	
Received date:	
Added to list by:	
Added date:	