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**COVID-19 Testing Partner Request**

**Instructions:** Please answer all questions. Scan and email the completed request form to: [COVIDTesting.BDCLab@baltimorecity.gov](mailto:COVIDTesting.BDCLab@baltimorecity.gov)

**Applicant Information**

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| --- | --- | --- | --- | --- | --- |
| **Name of Entity Submitting Request:** |  |  |  | **Request Date:** |  |
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| **Address:** |  |  |
|  | *Street Address* | *Suite/Unit #* |

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|  |  | | | |  |  | | | |  |
|  | *City* | | | | *State* |  | | | | *ZIP Code* |
| **Is this the primary applicant a clinical entity?** | | YES | NO | **If the primary applicant is not a clinical entity, please indicate the name of your clinical partner here:** | | |  |  |
| **\_\_\_\_\_** | | | | | | | | | | |

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| **Authorized Point of Contact for this Request:** |  | **Tel:** |  |

*Last, First MI*

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| **Email:** | **\_\_\_\_\_** | **Fax:** |  | **Website:** |  |

**Program Description**

**Please provide brief, but complete answers to the following questions.**

1. **Describe why your organization is applying to this program. Responses must include: identified community need, a description of the area(s) of the city where COVID-19 testing will occur (location(s), priority population(s), etc.**
2. **Describe your clinical workflow for COVID-19 testing in each setting where testing will occur. Responses must include: a description of the physical location(s) where testing will occur (including entry and exit), client/patient access (appointment, walk up, or drive up), registration including any foreseen testing costs to the client, isolation guidance, etc.**
3. **Describe your COVID-19 testing staffing structure for each type of location where testing will occur. Responses must include the total number of staff involved with COVID-19 testing, and training provided to conduct the test.**
4. **What infection control measures will you have in place when testing beings? Responses must include information on: infection control for staff and patients/clients, cleaning agents, social distancing measures for staff and patients/clients, types and amount of personal protective equipment (PPE) for each staff member.**
5. **Describe your proposed chain of custody and storage of collected specimen.**
6. **Describe your plan for providing clients/patients with results. Responses must include: system for the provision of results to patients/clients, reporting of positive cases for investigation and contact tracing, guidelines for isolation or quarantine if necessary.**
7. **Who will be the ordering physician for COVID-19 testing?**

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| **\_\_\_\_\_** |  |

*Last, First MI Degree*

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| **Tel:** | **\_\_\_\_\_** | **Email:** |  |  |

1. **Who will be the infection control supervisor for COVID-19 testing?**

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| **\_\_\_\_\_** |  |

*Last, First MI Degree/License*

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| **Tel:** | **\_\_\_\_\_** | **Email:** |  |  |

1. **Who will be responsible for data reporting to BCHD?**

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| **\_\_\_\_\_** |  |

*Last, First MI*

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| **Tel:** | **\_\_\_\_\_** | | | | | **Email:** |  |  |
| 1. **Is this an request for a one-time testing event?** | | YES | NO |
| 1. **Will your clinic need BCHD’s courier service to drop off test kits and pick up collected specimens?** | | YES | NO |  |

1. **Please provide the address/es where COVID-19 testing will be conducted. Include the day(s) of the week and time(s) of the day.**

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| 1. **Expected Start Date:** |  |  | |  |  | | --- | --- | | **Expected End Date:** |  | |

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| 1. **Estimated number of tests to be conducted per day:** |  |  |  |  |  |  |

**Disclaimer and Signature**

***I certify that I am authorized to submit this request on behalf of my organization.***

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| --- | --- | --- | --- |
| Name: |  | Signature: |  |