COVID-19 Testing Supplies Memorandum of Understanding (MOU)

INSTRUCTIONS

Complete this form in its entirety and return via email at COVID19.Testing@tn.gov.
If an organization has multiple locations that are to be supplied with COVID-19 testing supplies covered by this MOU, please list the facility name, address, and primary point of contact for each location on the additional page provided.
All fields are required.

ORGANIZATION

Name of Organization, Facility, or Practice

Address where testing supplies are to be shipped | Building, Floor, Suite Number

City | State | Zip Code | County

☐ Check here if multiple locations from one organization are to be supplied with COVID-19 testing supplies covered by this MOU. If so, please list the facility name, address, and primary point of contact for each location on the additional page provided.

_____ Number of associated locations that are to be supplied with COVID-19 testing supplies covered by this MOU.

MEDICAL DIRECTOR
Medical Director (or equivalent) of organization, facility, or practice must have an active and unencumbered TN medical license. Write N/A if this organization does not have a medical director)

Name | Credentials | Title

TN Medical License Number | National Provider Identifier (NPI) | E-mail

POINT OF CONTACT (POC)
Point of Contact (POC) is the person completing this MOU on behalf of the organization, facility, or practice.

Name | Credentials | Title

( ) - | ( ) - |
Phone | Fax | E-mail

AGREEMENT OF UNDERSTANDING
The State of Tennessee, through federal COVID-19 relief funding, has procured COVID-19 testing supplies to provide to certain Tennessee agencies for the purpose of performing testing on symptomatic individuals and for limited surveillance testing. In accepting the statements below, this organization (and associated facilities) agrees to abide by the following guidelines in exchange for being provided these testing supplies.

Please indicate your agreement to each of the conditions by checking "Accept" beside each statement.

The requesting organization and associated facilities agrees to:

☐ Accept 1. Provide COVID-19 testing to individuals who report symptoms consistent with COVID-19, who have exposure to someone who has been diagnosed with COVID-19, or who are tested as part of the organization's COVID-19 surveillance testing strategy.

☐ Accept 2. Store and handle the testing supplies in accordance with the package insert provided with the testing supplies.

☐ Accept 3. Report all test results to the Tennessee Department of Health (TDH) within 24 hours of receiving notification of results (unless a commercial laboratory is used that reports automatically to the State) and report all positive test results to the local health department immediately upon notification of those results. Fax PH1600 form to 615-741-3857. https://www.tn.gov/content/dam/tn/health/documents/reportable-diseases/PH-1600.pdf

☐ Accept 4. Record the individual's testing information in an office log that includes the date of testing, the date of the result notification, the result of the test, the source of specimen collection (nasopharyngeal, nasal, saliva, oropharyngeal), the method of specimen collection (health care provider collection, observed self-collection, self-collection), if the individual had known exposure to COVID-19, if the individual was symptomatic at the time of testing, date of onset of symptoms, the date of notification to Tennessee Department of Health (TDH), the date of notification to the local health department if the result was positive, and the date the individual was notified of test results.

AGREEMENT OF UNDERSTANDING (cont'd.)

In addition, the requesting organization:

☐ Accept 5. Shall not charge individuals, health insurance plans, or other third-party payers for the test or any testing supplies provided at no cost to the organization.

☐ Accept 6. Must report the number of tests conducted each week and the numbers of positive and negative results (aggregate, de-identified data) to COVID19.Testing@tn.gov.

☐ Accept 7. Must provide the individual with a written record of their test result and date of testing unless the patient has access to their results via an online portal.

☐ Accept 8. Shall assure that all persons participating in the COVID-19 testing program at this organization are made aware of their obligations under the terms of this agreement.

☐ Accept 9. Shall not refuse to provide testing to an eligible individual until notified by the State of Tennessee that the testing initiative has been suspended or discontinued.

☐ Accept 10. Acknowledges that negative results obtained through rapid antigen testing should be confirmed by molecular-based testing (PCR).

Additional conditions – the testing organization acknowledges that:

☐ Accept 11. TDH reserves the right to inspect testing supply inventory at will.

☐ Accept 12. TDH reserves the right to recall or redirect issued testing supplies as dictated by the department's outbreak response needs.

☐ Accept 13. The timing and amounts for distribution of these testing supplies will be at the sole discretion of TDH.

Medical Director (or Authorized Designee) Signature _____ Date _____

INTERNAL USE ONLY

Dr. Lisa Piercey, MD, MBA, FAAP
Commissioner, Tennessee Department of Health

Date _____

COVID-19 Testing Supplies
Memorandum of Understanding (MOU)

ORGANIZATIONS WITH MULTIPLE LOCATIONS

Name of Organization

FACILITY # 1

Name of Facility or Practice

Address where testing supplies are to be shipped | Building, Floor, Suite Number

City | State | Zip Code | County

POINT OF CONTACT (POC)

Name | Credentials | Title

( ) - | ( ) - |
Phone | Fax | E-mail

FACILITY # 2

Name of Facility or Practice

Address where testing supplies are to be shipped | Building, Floor, Suite Number

City | State | Zip Code | County

POINT OF CONTACT (POC)

Name | Credentials | Title

( ) - | ( ) - |
Phone | Fax | E-mail

FACILITY # 3

Name of Facility or Practice

Address where testing supplies are to be shipped | Building, Floor, Suite Number

City | State | Zip Code | County

POINT OF CONTACT (POC)

Name | Credentials | Title

( ) - | ( ) - |
Phone | Fax | E-mail

COVID-19 Testing Supplies
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ORGANIZATIONS WITH MULTIPLE LOCATIONS (cont'd.)

Name of Organization

FACILITY # 4

Name of Facility or Practice

Address where testing supplies are to be shipped | Building, Floor, Suite Number

City | State | Zip Code | County

POINT OF CONTACT (POC)

Name | Credentials | Title

( ) - | ( ) - | |

Phone | Fax | E-mail

FACILITY # 5

Name of Facility or Practice

Address where testing supplies are to be shipped | Building, Floor, Suite Number

City | State | Zip Code | County

POINT OF CONTACT (POC)

Name | Credentials | Title

( ) - | ( ) - | |

Phone | Fax | E-mail

FACILITY # 6

Name of Facility or Practice

Address where testing supplies are to be shipped | Building, Floor, Suite Number

City | State | Zip Code | County

POINT OF CONTACT (POC)

Name | Credentials | Title

( ) - | ( ) - | |

Phone | Fax | E-mail