APPENDIX B-20
Mass Vaccination: Clinic Organization & Personnel Estimates.

Reference: CDC Smallpox Response Plan, Annex 3, Smallpox Vaccination Clinic Guide, 23 September 2002. http://www.bt.cdc.gov/DocumentsApp/Smallpox/RPG/.

1. This section describes a model of a vaccination program involving administration of smallpox vaccine under an investigational new drug (IND) protocol, as well as an example of personnel estimates for clinic staffing. The output goal of this example clinic model would be the administration of vaccine to 1 million people over 10 days. The model can be expanded or contracted, as needed, to address changes in vaccination administration goals for different population areas.

a. These staffing estimates were derived by CDC from: 1) review of previous large-scale-clinic models and publications, 2) considerations of requirements for administering an IND vaccine, and 3) computer modeling for clinic flow and output estimates with different example staff numbers. Parameters of low and high completion times for specific activities within the clinic were estimated. The time requirement for these activities may differ depending on the demands placed on the vaccine clinic system and could require adjustment of staffing. Local planners should evaluate these activity-time estimates and consider what staffing or flow adaptations may be needed to accommodate increases or decreases in activity-time requirements. The computer modeling of the example clinic to determine staffing needs utilized the following parameters:

- 97% of people presenting to clinic will be processed through the normal clinic flow.
    - 1% will have some illness that will require evaluation before processing through the clinic.
    - 2% will be identified as a contact or possible contact to smallpox and will be processed through the separate “contact evaluation” unit.
- 20% of people coming through the clinic will require medical counseling in addition to the orientation video.
    - Medical counseling/questions will require 5 to 15 minutes (recognizing that some individuals will require > 15 minutes and others will require < 5 minutes).
    - Physicians will be available to handle more difficult medical screening to keep clinic flowing.
- 50% of persons getting additional medical counseling (i.e., the 20% above) will be vaccinated, and 50% will defer vaccination because of contraindications or other reasons.
- Distributing IND packets and providing initial instructions would take between 30 seconds and 2 minutes.
- Video orientations will be done approximately every 30 minutes in 5 orientation rooms that hold 75 people per room.

- Individuals will take 2 to 3 minutes to fill out the medical history screening forms.
- Vaccination and completing vaccination cards would require between 0.5 and 2 minutes.

b. The numbers shown in the table below are estimates of the human resources needed with the above clinic assumptions and configuration. Changing the assumptions can be explored to determine ways to further maximize clinic output and human-resource utilization. Although staff numbers may vary depending upon the assumptions and clinic output requirements, the general tasks that must be addressed within the clinic (e.g., patient education, medical history screening, medical counseling, vaccination) would not change.

c. CDC plans to make available to public-health officials a software program ("Maxi-Vac") that will allow officials to further refine human-resource needs (e.g., physicians, nurses, other staff) to maximize patient flow-through. Conversely, this software program may also be used to determine maximum vaccination output that may be achieved with different human-resource estimates.

d. The model assumes that clinics can be operating at near full efficiency to meet vaccination goals once the decision to offer voluntary vaccination is made.

2. Clinic Estimates

Vaccination Clinics (VC)	20 clinic sites	More sites could be added to accommodate larger population bases.
Vaccination Stations (VS)	▪ 8 VS per shift ▪ 1 vaccinator per station ▪ 0.5 to 1 witness/helper per station (who can also alternate vaccinating) ▪ 16 vaccinators/witnesses per shift	
Hours of Operation	At a minimum 16 hours per day	Consider expanding hours for higher daily output or to address overflow.
Vaccination Delivery	▪ 30 to 60 vaccinations per VS per hour ▪ ~ 370 vaccinated per VC per hour ▪ ~ 5,900 vaccinated per VC per day ▪ ~ 118,000 per day total with 20 VC ▪ 1 million vaccinated in ~ 9 days	30 to 60 vaccinations per VS per hour allows for variations caused by vaccinator rotation, resupply requirements, completing vaccination card, and other considerations.

3. Breakdown of Clinic Personnel per Vaccination Clinic.

Position	Number per 8-hour Shift	Number per 16-hour Day	Experience
Forms Distribution +	9	18	Nonmedical volunteers

Triage for Ill or Contact	2	4	Nurse or EMT
Run Orientation Video	8	16	Nonmedical (five running rooms and three floating between rooms to assist)
Referral Personnel	16	32	Nonmedical volunteers
Medical Screeners	7	14	Medical training required nurse or MD
Physician Evaluators	2	4	Physicians to evaluate ill or more difficult medical history screening
Vaccinators, Witnesses, Surge Staff	16	32	Cross-trained to alternate vaccination, fill out vaccine card, and sign as witness
Vaccine Preparation, Supply to VS	2	4	Pharmacist, pharmacy technician, nurse familiar with medication reconstitution
Exit Review	2	4	Medical or public-health personnel for final questions and instructions
Medical Records/Data Entry	10	20	Nonmedical, data entry for information collected on vaccinees
Clinic Manager	2	4	Existing Vaccine Program Personnel
Supply Manager	2	4	Nonmedical
Clinic Flow, QA Review, Form Helpers	8	16	Nonmedical volunteers to assist with forms completion, collection, and clinic flow
Security	20	40	Non-public health resource
Traffic Flow	2	4	Nonmedical, assist with loading/unloading buses at site, if offsite parking utilized
Translator (not counted in total clinic staffing estimates)	$\geq$ 1 per major language per shift	Unknown	Language fluency with training
Float Staff	3	6	Nonmedical volunteers
Contact Evaluation	4	8	Public health
EMT	1	1	Medical
Information Technology (IT) Support	1	2	Nonmedical
Total Personnel	**117**	**234**	

- FORMS/INFO PACKET DISTRIBUTION – 9 x 2 shifts = 18 total – Personnel to assemble patient forms/information packets and hand out packets with information sheets/registration forms/informed consent/other IND forms (1 minute/person), clipboards, and pencils. People will begin filling in demographic information on forms while in line awaiting initial clinic entry for video briefing.

- TRIAGE [nurse or EMT] – 2 x 2 shifts = 4 total – Triage personnel to direct ill patients to other evaluation facilities and direct identified contacts, persons with contact with a case of rash illness in last 3 weeks, and their household family members to high-priority evaluation location within clinic (1 minute/person). Triage should also utilize signs explaining where people should go if they are ill or are identified contacts. [Note: Ill persons should be triaged out and evaluated at designated offsite parking sites before boarding bus for transportation to clinic if offsite parking with busing is used for clinics.]
- VIDEO ORIENTATION – 8 people x 2 shifts = 16 total – Personnel to run video orientation regarding clinic procedures, paperwork, IND consent information, reasons for vaccination, contraindications to vaccination; 5 rooms running concurrently that hold 75 people/session with 2 staff/room (~20 minutes per session, allowing for 5 to 10 minutes for moving people into and out of orientation room) or a total of approximately 2 sessions/hour (~750 people oriented/hour).
- REFERRAL PERSONNEL– 16 people x 2 shifts = 32 total – Can be trained volunteers with no medical background; to look at medical screening/vaccination consent forms and send persons without “yes” checked boxes who have signed form on to vaccination station and redirect people with contact checked boxes or other “yes” or “maybe” checked boxes on to contact or medical screeners. Float staff personnel can relieve as needed to allow all stations to continue running during staffing breaks.
- MEDICAL SCREENERS FOR CONTRAINDICATIONS, EVALUATION/INFORMED CONSENT QUESTIONS COUNSELING (should be medically trained personnel, such as physicians, nurses, physician assistants, or nurse practitioners) –– 7 per shift x 2 shifts = 14 total – Medical screeners to review patient history for those with contraindications and answer questions for informed consent (~ 5 to 10 minutes/person); numbers may need to be increased if too many people require further screening and lines start to back up at this part of clinic.
- PHYSICIAN EVALUATORS – 2 x 2 shifts = 4 total – Physicians to evaluate/examine triaged ill persons and provide backup counseling if needed to contacts and noncontacts identified with possible contraindications by medical screeners (~ 10 minutes/person), and evaluate any immediate problems following vaccination (e.g., fainting or anaphylaxis).
- VACCINATORS/ASSISTANTS – 16 x 2 shifts = 32 total – Eight vaccination stations with 1.5 to 2 vaccinators per vaccination station/shift to trade off vaccination, fill out vaccination card, and witness/collect signed vaccination consent/med screening form (each of the eight stations vaccinating 35 to 45 people/hour for total of 360 people vaccinated/hour). Vaccinators should consist of those allowed to administer vaccine under state law.
- VACCINE PREPARATION FOR VS – 2 x 2 shifts = 4 total – For preparation of vaccine vials to supply VS as needed. Should be pharmacist, pharmacy technician, or other personnel trained in preparation of medications or reconstitution of vaccines and as allowed by state law.
- EXIT REVIEW PERSONNEL – (should be medical or public health personnel) 2 x 2 shifts = 4 total – Personnel to answer any final questions about site care, adverse

event symptoms or non-take reporting procedures/follow-up, and other issues following vaccination.

- MEDICAL RECORDS/DATA ENTRY PERSONNEL – 10 x 2 shifts = 20 total – Collect retained records and enter registration/vaccination information (e.g., name, Social Security number, passport number and country, and contact information) into database (estimated 1 minute/record entry if database already set up) – important to have onsite, if possible, to maintain "real-time" record of number of vaccinations and database for later use for adverse events or non-takes requiring revaccination; Web-based entry with centralized database of all clinics preferable.
- CLINIC MANAGERS – 2 x 2 = 4 total – Oversees all clinic functions/problem solving.
- SUPPLY MANAGERS – 2 x 2 = 4 total – Oversees all supply needs; tracks vaccine supply/lot numbers, distribution, and wastage; re-supplies vaccination stations.
- CLINIC FLOW/QA/FORMS HELPER PERSONNEL [volunteers] – 8 x 2 = 16 total – Help maintain clinic flow, assist with forms, quality assurance, retrieve clipboards and forms from VS and takes forms to medical record entry personnel and clipboards back to form distribution, rotate through waiting areas to answer questions, and talk with people to assure them, as needed.
- SECURITY PERSONNEL – 20 x 2 = 40 total – Maintain crowd control outside and security within clinic; assist with clinic and traffic control, and other security matters. Non-public health resource; however, arrangements must be made with appropriate agencies or organizations to provide security as part of coordinated planning.
- TRAFFIC FLOW PERSONNEL – 2 x 2 = 4 total – Maintain traffic flow and order in parking area if parking onsite; if busing from offsite parking is used, these personnel may not be needed.
- TRANSLATORS – One for each major language spoken in community per shift; more may be needed depending upon major language of clinic population. Translators proficient in sign language should also be identified to assist with deaf individuals. Local and state authorities should identify language translations needed based on makeup of the community. Consider identifying specific clinics for referral of populations who need translators.
- FLOAT STAFF PERSONNEL [volunteers] – 3 x 2= 6 total – Float staff personnel to answer telephones, assist clinic personnel as needed, collect forms, assist with handicapped and elderly, and similar functions.
- CONTACT EVALUATION UNIT PERSONNEL – 4 x 2 = 8 total – For separate medical screening, education, and registering of identified contacts and their household contacts. Contacts will also be registered for surveillance for smallpox symptoms and given instructions on any travel restrictions and reporting requirements. Must be educated on contact surveillance process, smallpox signs/symptoms, and contact evaluation issues.
- EMT – 1 x 2 = 2 total – To assist with medical emergencies, fainting, and similar situations.
- IT PERSONNEL – 1 per shift x 2 = 2 total – To support computer, programming, electronic equipment maintenance needs, and other information technology requirements.

Although not formally included in the above staffing estimates, the addition of mental

health staff at each clinic site should be considered.

4. Other Volunteers As Needed For Float Staff, Forms Assistance, Referral Personnel, And Related Clinic Activities.

a. VC Staff needed per single vaccination clinic (VC) to cover two 8-hour shifts – approximately 234 (117 per shift) + translators. Note: 40 people are security people from outside public-health resources.

b. Nonmedical volunteers can be used for: forms distribution, orientation video, referral personnel, data entry, supply manager, clinic flow/QA/forms assistance, security, traffic flow, translators, float staff, and IT support.

c. Total Staff needed for 20 Vaccination Clinics – 234 per VC x 20 VC = 4,680 personnel. Planners should consider increasing staffing by approximately 20% with cross-trained personnel to allow for absences, breaks, surge needs, and other contingencies. Note: ~ 17%, or 800, of these personnel should come from outside public-health resources to provide security.

5. Considerations for Assessing Vaccine Non-Takes and Adverse Events. Medical authorities should establish telephone lines for the following purposes:

a. Reporting and Handling of Vaccination Non-Takes.

(1) Noncontacts: Vaccinated individuals who are not otherwise identified as contacts to a smallpox case will be given vaccination cards and vaccination-take recognition cards at the time of their vaccination and instructed to call a designated number, if their vaccination site does not resemble the picture on the card at day 7. If they apparently have a vaccine non-take, they will be counseled through the hotline to return to a vaccination clinic (VC) with their vaccination card for revaccination. Individuals presenting back to VC for revaccination would not require repeat medical screening as long as they present their vaccination card from the previous VC visit, but may be required to review the informed consent material (video) and sign an additional consent form. Following this signing, they can be triaged directly to the vaccination area for revaccination.

(2) Contacts: Vaccinated contacts under surveillance and their household members will also receive vaccination-take recognition cards and vaccination cards. If possible, they will be followed up with visual confirmation of vaccine take as a part of the contact surveillance process. If visual confirmation is not possible because of a large number of contacts requiring surveillance by limited personnel, contacts and their household members will be instructed to report possible vaccine non-takes to a designated contact symptom surveillance telephone number at the local or state health department. Revaccination will be done for contacts and their household members who do not have a vaccine take at day 7. This revaccination may be done through referral back to the contact evaluation unit of a VC, referral to another specified location, or through direct

administration of vaccine by health department personnel at the time of visual evaluation.

b. Reporting, Evaluation, and Treatment of Suspected Adverse Events. Evaluation and treatment for vaccine adverse events should occur at a designated site or sites separate from VCs. Medical authorities should identify and staff a local telephone number for reporting of suspected adverse events. This number should be included with the Smallpox Vaccine Information Statement (VIS) handed out to vaccine recipients. Staff should be instructed on where to refer callers for further medical evaluation. As a part of smallpox bioterrorism (BT) planning, health authorities should designate the facilities where suspected vaccine adverse events will be referred, evaluated, and treated. For the DoD reporting and consultation mechanism for healthcare providers to report potential VIG-requiring adverse events, see Annex H.

6. Additional Considerations.

a. Mobile Facilities. Consider mobile facilities (for nontransportable populations) if needed for fixed population vaccination:

(1) Retirement communities, nursing homes, hospitals, prisons, or other residential facilities

(2) Defined high-density areas/facilities, such as apartment and housing complexes

b. People with Disabilities. Vaccination clinics must have accessibility for people with disabilities for clinics and transportation vehicles to clinics. Consider acquiring wheelchairs to assist the elderly who cannot ambulate from station to station.

c. Referral Testing. Strategies for the referral of persons who request HIV or pregnancy testing to local laboratories or medical clinics that perform confidential testing should be considered and communicated as a part of the overall clinic planning. Planners should maintain a list of local laboratories that offer this testing. In addition, consideration should be given to the potential use of rapid HIV tests within these clinics if an FDA-approved test is available.

d. Waste Disposal. Two to three disposal trucks and staff will be needed to collect medical and other waste from 20 VCs at least daily.

e. Rest Area. An area is needed for staff to rest or sleep if working more than 8 hours or if there is inclement weather and staff are unable to return to their homes after their shift.

f. Transportation for Staff. Depending on the location, arrangements may be needed to transport staff to the VC.

7. Public Announcements. Use television and radio networks to present uniform messages. Planners should consider how these messages could be quickly developed, locally, to accommodate sudden changes in sites and/or recommendations. Establish a list of non-English speaking media outlets that can be utilized to deliver messages to immigrants/refugees and other non-English speaking communities. Messages should state that a plan is being put into operation, conveying:

- urgency and patience, but not panic
- the number of VCs
- timing to prevent smallpox (i.e., vaccination 4 days after exposure is effective)
- vaccine supply
- trained personnel
- listing of collection areas where people will be picked up by buses
- materials to bring to clinic(identification to prove eligibility, loose clothing to allow easier vaccination)
- listing of normal activities being suspended
- hotline numbers
- review of vaccine recommendations.
- frequently updated “wait-times” for vaccination clinics to help determine clinic utilization.

8. Logistics for IND Administration of Smallpox Vaccine.

a. Triage for Illness: The first triage point for the vaccination clinic is triage for illness and/or contacts of confirmed cases of smallpox. This checkpoint is to screen out those individuals that may be ill or contacts from the rest of the individuals at the clinic so as not to expose the clinic population.

(1) Ill (e.g., fever or rash): These individuals will be taken out of the mainstream flow prior to entering the clinic and will be attended to as required by their symptoms/illness (e.g., monitoring, referral, supportive care).

(2) Contacts: These individuals will be taken out of the mainstream flow to be counseled on follow-up procedures and registered for monitoring for symptoms of smallpox. They will also be vaccinated.

(3) Not Ill (mainstream progression through the clinic): Those individuals that will progress to the next station within the clinic who have not presented as ill or a contact.

b. Distribution of Information Packet: All individuals (contacts and mainstream) will receive the “mainstream” information packet that will include the following information:

(1) Video script

(2) Screening form

(3) Vaccine Information Statement (VIS)

(4) Vaccination Site Care Card

(5) Proof of Vaccination Card

c. After receiving this information, “mainstream” individuals will proceed to the video screening area, while “contacts” will proceed to the contact evaluation area.

(1) Video Screening Areas: Individuals will view the video that contains the essential elements of informed consent as promulgated in 21 CFR 50.25. This video viewing will be witnessed to comply with FDA regulations for the oral presentation of consent information. The script of the video is included in the “mainstream” packet and will include, at a minimum, English presentations and Spanish language translations. Additional language translations may be needed at the local level to address special populations.

(2) After the video, the individuals will be instructed to complete the screening form that will move them through the remainder of the vaccination clinic.

(3) Post-video Triage: Individuals will proceed to this triage point with their completed screening forms. The screening forms are for self-identified contraindications for the individual or family members with contraindications (e.g., contact history, altered immune status, autoimmune diseases, concomitant medications that alter immune status, skin conditions, pregnancy, reactions to previous smallpox vaccinations, allergies to vaccine components, children less than 1 year old) and/or questions relating to the decision to be vaccinated.

(4) If individuals check “yes” or “maybe” to any of the boxes on the screening form, they will proceed to the counseling stations where they will receive additional information based on the contraindication that they checked.

(5) If individuals have no self-identified contraindications or questions, they will proceed to the vaccination area.

(6) If individuals decide to decline vaccination and are not a contact, they will be escorted to the exit.

d. Vaccination Area:

(1) At the vaccination station individuals who did not require additional counseling will sign the consent form located on the back of their Medical History Screening Form that states that they have viewed the video and had all questions answered. They will also have the chance here to ask any remaining questions; if they do have remaining questions, they may be referred back to the counseling area. Once signed by the vaccinee, these forms will be signed by the vaccinating assistant as a “witness to consent” and then collected.

(2) Individuals who were referred to the vaccination stations after receiving additional counseling will have had their consent forms witnessed by the medical counselor and will proceed with vaccination.

(3) Following vaccination, the “Proof of Vaccination” form will be stamped by the vaccinating assistant and returned to the vaccinee.

(4) Any noncontact who refuses vaccination will be allowed to exit the clinic. Contacts who decline vaccination will be instructed on appropriate quarantine measures, the symptoms to monitor for, and appropriate contact information within the “Contact Evaluation Unit” area.

e. Post-Vaccination Information and Review: This is the final station in the clinic for any remaining questions. This station should also ensure that individuals exit with *all* their information sheets and instructions. (A supply of extra information sheets should be kept here to distribute, as needed.)

APPENDIX B-21
Mass Vaccination: Clinic Preparation Checklists.

Reference: CDC Smallpox Response Plan, Annex 3, Smallpox Vaccination Clinic Guide, 23 September 2002. http://www.bt.cdc.gov/DocumentsApp/Smallpox/RPG/.

1. Overall Planning and Management Checklist.

- ❑ Installation or Command Headquarters Identified
- ❑ Location
- ❑ Staffing for General Operations
- ❑ Staffing for Problem-Solving
- ❑ Memoranda of Understanding (as required)
- ❑ Communications Protocol
- ❑ Central Vaccine Storage Site Identification
- ❑ Central Facility with Security and Backup Generator
- ❑ Central Supplies Warehouse
- ❑ Shipping Company Selection
- ❑ Printing Company Selection (for mass form production)
- ❑ All Supply Resources Identified (see Supply and Equipment Checklist)
- ❑ Vaccination Clinic Site Identification (x20)
- ❑ Procedure for Designating Vaccination Site/Time (i.e., zip code? SSN?)
- ❑ Procedure for Identification
- ❑ Computer Networking Identified for Exchange of Data
- ❑ Standing Orders for Emergencies
- ❑ Agreement(s) with local media for public service announcement coverage/production

2. Smallpox Post-Outbreak Clinic Site Checklist.

Clinic Site: Number of

☐ Facility Resources

- ☐ Large, open space to accommodate clinic flow
- ☐ Weather protection for those in line
- ☐ Portable toilets to accommodate waiting lines
- ☐ Ability to be made secure
- ☐ Backup generator
- ☐ Accessible for people with disabilities
- ☐ Ease of access for community
- ☐ Communication resources available
- ☐ Equipment resources available (See Supply and Equipment Checklist)
- ☐ Tables available
- ☐ Screening rooms available
- ☐ Waste disposal
- ☐ Rest area for staff
- ☐ Transportation/parking for staff

☐ Transportation Procedures

- ☐ Parking identified
- ☐ Bus service company selection
- ☐ Routes for bus service

☐ Vaccination Clinic Personnel Identified (See Personnel Checklist)

- ☐ Vaccinators
- ☐ Physician evaluators
- ☐ Support functions

☐ HIV Testing and/or Referral Plan

☐ Equipment Resources Identified (See Supply and Equipment Checklist)

3. Supply and Equipment Checklist.

Clinic Site: Number of

Equipment Needs

- ☐ Copier
- ☐ Fax machine
- ☐ 12 computers or laptops
- ☐ 5 DVD or VCR players
- ☐ 5 Large-screen televisions
- ☐ Cell phones
- ☐ Handheld radios

General Supplies

- ☐ Tables
- ☐ Chairs
- ☐ Water and Cups
- ☐ Paper
- ☐ Pens, Pencils
- ☐ Envelopes
- ☐ Rubber Band
- ☐ Tape
- ☐ Stapler/Staples
- ☐ Paper Clips
- ☐ Scissors
- ☐ Post-It Notes
- ☐ File Boxes
- ☐ Telephone
- ☐ Paper Towel
- ☐ Tissues
- ☐ Table pads, clean paper
- ☐ Garbage containers
- ☐ Trash bags
- ☐ ID Badges for staff
- ☐ 7 Copies of Video
- ☐ Food and drink for staff
- ☐ List of emergency phone #s
- ☐ Cleaning supplies

Crowd Management and Triage Supplies

- ☐ Queue Partitions
- ☐ Signs for Site Designation
- ☐ Signs for Clinic Flow

Vaccine Administration Supplies

- ☐ Smallpox Vaxicools/Refrigerator
- ☐ Vaccine Diluent
- ☐ Sterilized Bifurcated Needles
- ☐ Sharps Containers
- ☐ Latex Gloves
- ☐ Latex-Free Gloves
- ☐ Anti-bacterial hand washing solutions
- ☐ Acetone
- ☐ Rectangle Band-Aids
- ☐ Gauze
- ☐ Adhesive Tape
- ☐ Spray Bottle of Bleach Solution
- ☐ Paper Gowns
- ☐ Vaccination Screens

Emergency Supplies

- ☐ Standing Orders for Emergencies
- ☐ “Code” kit with defibrillator
- ☐ Ampules of Epinephrine 1:1000 SC, or
- ☐ Epi-Pen Adult and Epi-Pen Pediatric
- ☐ Ampules of diphenhydramine (50 mg IM)
- ☐ 3 ml syringes with 1”, 25-guage needles
- ☐ 1.5” needles
- ☐ Tuberculin syringes with 5/8” needles
- ☐ Alcohol Wipes
- ☐ Blood Pressure Cuffs (Various Sizes)
- ☐ Oxygen Tank
- ☐ Oxygen Tank Tubing
- ☐ IV Solution
- ☐ IV Solution Tubing
- ☐ Thermometer
- ☐ Aspirin, Tylenol, Regular insulin, D50
- ☐ Asthma Inhaler
- ☐ Tongue Depressors
- ☐ Emesis basis
- ☐ Adult pocket masks with one-way valve
- ☐ Pediatric pocket masks with one-way valve
- ☐ Adult and pediatric airways
- ☐ Tourniquet
- ☐ Gurney
- ☐ Stethoscope
- ☐ Flashlight
- ☐ Cots, Blankets, and Pillows
- ☐ ER Report Form

4. Personnel Checklist.

Clinic Site: Number of

☐ Forms Distribution

AM Shift

1. 6.
2. 7.
3. 8.
4. 9.
5.

PM Shift

1. 6.
2. 7.
3. 8.
4. 9.
5.

☐ Triage for Ill People or Contacts of Smallpox Cases

AM Shift

1. 2.

PM Shift

1. 2.

☐ Run Orientation Video

AM Shift

1. 5.
2. 6.
3. 7.
4. 8.

PM Shift

1. 5.
2. 6.
3. 7.
4. 8.

☐ Referral Personnel

AM Shift

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.

PM Shift

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.

☐ Medical Screeners

AM Shift

1.
2.
3.
4.
5.
6.
7.

PM Shift

1.
2.
3.
4.
5.
6.
7.

☐ Physician Evaluators

AM Shift

1.
2.

PM Shift

1.
2.

☐ Vaccinators

AM Shift

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

PM Shift

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

☐ Vaccine Preparation/Supply

AM Shift

1.	2.

PM Shift

1.	2.

☐ Exit Review

AM Shift

1.	2.

PM Shift

1.	2.

☐ Medical Records/Data Entry

AM Shift

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

PM Shift

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

☐ Clinic Manager

AM Shift

1. 2.

PM Shift

1. 2.

☐ Supply Manager

AM Shift

1. 2.

PM Shift

1. 2.

☐ Clinic Flow/Quality-Assurance Reviewer/Forms Helpers

AM Shift

1. 5.
2. 6.
3. 7.
4. 8.

PM Shift

1. 5.
2. 6.
3. 7.
4. 8.

☐ Security

AM Shift

1. 16.
2. 17.
3. 18.
4. 19.
5. 20.
6. 21.
7. 22.
8. 23.
9. 24.
10. 25.
11. 26.
12. 27.
13. 28.
14. 29.
15. 30.

PM Shift

1. 16.
2. 17.
3. 18.
4. 19.
5. 20.
6. 21.
7. 22.
8. 23.
9. 24.
10. 25.
11. 26.
12. 27.
13. 28.
14. 29.
15. 30.

☐ Traffic Flow

AM Shift

1. 2.

PM Shift

1. 2.

☐ Translators

AM Shift
1. Language:
2. Language:

PM Shift
1. Language:
2. Language:

☐ Float Staff

AM Shift
1. 3.
2. 4.

PM Shift
1. 3.
2. 4.

☐ IT Support

AM Shift
1.

PM Shift
1.

☐ Contact Evaluation

AM Shift
1. 3.
2. 4.

PM Shift
1. 3.
2. 4.

APPENDIX B-22
Alternate Housing Arrangements..

Situation:

A person is eligible for smallpox vaccination due to duty assignment and medical history. However, that person has a household contact (e.g., spouse, child) who has a medical contraindication (e.g., eczema, immune-suppression, pregnancy) related to the vaccinia virus within smallpox vaccine. By DoD policy, exempt individuals should be physically separated and exempt from duties that pose the likelihood of contact with potentially infectious materials (e.g., clothing, towels, linen) from recently vaccinated people. This separation will include not having the vaccine recipient share or alternate use of common sleeping space (e.g., cot, bunk, berth) with people with contraindications to vaccination.

The risk to be avoided is the spread of vaccinia virus from the vaccination site to another person by inadvertent contact, either directly, or by means of clothing, towels, sheets, or other common-access items that could transfer the virus. Historically, the rate of spread of vaccinia virus to contacts was quite rare, about 27 cases per million vaccinations. DoD's goal is to reduce the risk as much as possible.

Unacceptable:

Permitting a vaccinated Service Member to reside in a house, trailer, apartment, or similar close arrangements (e.g., "hot-bunking") with a medically-barred contact is unacceptable, until the scab falls off on its own.

Acceptable:

Having the vaccinated Service Member use alternate lodging (e.g., barracks, dormitory room, tents) on a military installation, vessel, or aircraft, or in contracted space, is acceptable.

Having the vaccinated Service Member voluntarily arrange for alternate lodging in privately-owned or managed space is acceptable, if the commander has a reasonable expectation that the Service Member will comply with the requirement to not share living and toileting space with a medically-barred household contact.

Berthing barges, familiar to naval forces whose berthing spaces were refitted during a shipyard period, can be used at naval installations near the water.

The vaccinated Service Member can continue to have reasonable access to a medically-barred household contact, so long as the access includes careful hand-washing and does not involve extensive physical contact or contact involving clothing, sheets, towels, or other items likely to transfer vaccinia virus.