OhioHealth

Automated Dispensing Cabinets
User ID/Password Request Form

User Access Request Form and Confidentiality Agreement

Please complete the following to obtain your User ID and initial password for the Automated Dispensing Cabinet system. It will be used to access patient medications and/or supplies in your assigned work area (e.g. nursing unit, procedural area, etc). The first time you access the Automated Dispensing Cabinet system, you will be required to enter a new, confidential password and enroll your fingerprint scan(s) using BioID. ***It is your responsibility to keep your new password secret and utilize your BioID access for personal access only.*** You will be accountable for all transactions performed under your User ID and confidential password/BioID. Please read and sign the following statement to verify that you understand this statement, and to acknowledge that you will maintain the integrity of your password/BioID access once you change your password and/or enroll your fingerprint scan(s) using BioID.

Upon accessing the Automated Dispensing Cabinet system for the first time, I will change my initial password to a new, confidential password and enroll my fingerprint scan(s) using BioID. I understand that my User ID and password/BioID will be my electronic signature for all transactions on the Automated Dispensing Cabinet system. I understand that no retrievable record of my new password or BioID exists. All of my transactions on the Automated Dispensing Cabinet system will be permanently recorded with my User ID and a date and time stamp. These records will be maintained and archived per the policies of this hospital; and will be available for inspection by the Drug Enforcement Administration (DEA) and the State Board of Pharmacy, State Board of Health or other auditing agency, as is presently done with my handwritten signature for all other controlled substance records.

I also understand that to maintain the integrity of my electronic signature, I must not give my password to any other individual. Unauthorized access, release or dissemination of this information shall subject me to disciplinary action. Should I have any suspicion that my personal password has become known to another individual, I will change it immediately and, if deemed appropriate, will immediately report such to my supervisor.

CAMPUS: ☐ **DOCTORS** ☐ **DUBLIN** ☐ **GRADY** ☐ **GRANT** ☐ **RIVERSIDE** ☒ **OTHER (specify):** PICKERINGTON

REASON FOR REQUEST:

☒	New staff
☐	New / Extending Traveler **CONTRACT START/END DATES:**
☐	New / Extending Agency **CONTRACT START/END DATES:**
☐	Nursing Instructor **CONTRACT START/END DATES:**
☐	Password change (forgot password)

THIS USER IS A/AN:

☐	Staff RN/LPN	☐	Nurse Manager	☐	CRNA
☐	Traveler RN/LPN	☐	Nursing Instructor	☐	Pharmacist
☐	Agency RN/LPN	☐	Respiratory Therapist	☐	Pharmacy Technician / Intern
☐	SNAP RN/LPN	☐	Physician	☐	Other:

User Signature: _____ OPID: _____ Date: _____

Print Name: _____ Clock #: _____ Dept/Unit: _____

Authorized By:

Nurse Mgr or Instructor Signature: _____ Date: _____

Print Name: _____ Dept/Unit: _____

Please enter above information correctly and return the ORIGINAL (no copies or faxes) to Pharmacy

Pharmacy Authorization:

Signature:		Date:	User ID:
Print Name:		Entered into Console by:	Initial Password:

Revised 06/09