OMNICELL / MAK

PASSWORD VERIFICATION STATEMENT

Associate ID:____________________ **DATE:**__________________________

NAME:___________________________, ____________________ ___________________

Last **First** **Middle**

OMNICELL SIGN-ON:________________________________

(Assigned by Pharmacy)

MAK SIGN-ON: ______________________________________ **Unit:**____________________

CLASSIFICATION: (check one) ☑ **RN** ☐ **LPN**

Request Type: ___ **New** ___ **Change** ___**Terminated**

Employment Type: ___ **Full Time**___ **Part Time**___ **Whitfield Staffing** ________________**(Area)**

___ **Agency Nurse** **Ending Date:** ________________

___ **Travel Nurse** **Ending Date:** ________________

✔ **Student Instructor** **Ending Date:** ________________

- **Ending date required for temporary users. Note: Student Instructors can be active no longer than the end of the school semester.**

Requested Privileges: Nursing Supervisor_____________ **Nurse** ______✔_______

Direct Supervisor's Name:_____________ Robin Green RN _____________

<u>MedAdmin Statement for Nurse:</u>
I certify that I fully understand and will comply with the 7 rights of medication administration as required by the Medication Administration Check System.

<u>For Patient Safety:</u> I will not 'Chart' on paper or in the Medication Administration Check (MAK) System until the medication has been administered or ingested by the patient. I understand that the computer on wheels should be taken into the patient's room, just inside the doorway, when administering medication. I will follow proper procedure when scanning patients for identification. This is for patient safety and I am aware that bypassing proper procedure will not be tolerated. Any clinician observed or found on the MAK Reports to have scanned anything other than the patients armband affixed to the patient (i.e. labels or patient envelopes) will receive a formal write up. Upon three (3) write-ups for this occurrence, termination will occur.

Please be aware that our goal is to have ZERO (0) patient ID overrides and ZERO (0) medication ID overrides. REMEMBER - Safe administration of medication is a critical component in the overall care of neonatal, pediatric, adult, and geriatric patients. It is the responsibility of all associates involved in the administration of medication to adhere to defined standardized procedures. This includes the verification of prescriptions and orders and the identification of patients prior to the administration of the medication, via the Medication Administration Check (MAK).

____ **Signature of RN/LPN**

<u>Omnicell Statement for Director/Supervisor/Educator:</u>
I certify that the above associate has completed training on and is competent in the operation of Omnicell cabinets.

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Signature of Director / Nurse Supervisor / Nurse Educator

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* PHARMACY USE ONLY *

Date Processed:____________________________ **Processed By:**_________________________
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