Trainer's Signature:

OVERLAKE Hospital Medical Center
Medical excellence every day™

OMNISUPPLIER MEDICATION PASSWORD VERIFICATION STATEMENT

I understand that my access code, which consists of an identification code and a password, is my electronic signature for all transactions in the OmniSupplier. It will be used to track all of my transactions on the System and will be permanently attached to those transactions with a time/date stamp. These records will be maintained and archived as per the Facility policy and will be available for inspection by all regulatory bodies, (i.e., DEA, State Board of Pharmacy, etc).

My initial ID number will be assigned by the Pharmacy System Administrator. It is my responsibility upon receipt of this ID number to immediately sign on the OmniSupplier and enter a new password of my choice. There will be no record of this password; therefore, should I forget my password I must contact my Charge Nurse, Nurse Manager, or the Omnicell Systems Administrator.

I also understand that to maintain the integrity of my electronic signature, I must not give this password to any other individual. The individual Password is selected by, and known only to the user. This password is encrypted throughout the OmniCell System and cannot be accessed by Pharmacy Users, Nursing Management, or Omnicell employees. If for any reason I feel an individual has knowledge of my password, I must select a new password immediately and notify my Nurse Manager. A password can be reset by your Charge Nurse or Nurse Manager.

_____

Signature, legal name, **as it appears on your WA State License**

_____

FIRST **Middle Initial** **LAST**

Print Name, legal name, **as it appears on your WA State License**

_____

Job Title

_____

Unit / Department

_____

Date

This portion is to be completed only by the Trainer or Instructor.

Leave this box blank for regular employees.
*For all others, please check **one** box, then fill in appropriate dates.*

- ☐ Nursing Instructor
- ☐ Nursing Student
- ☐ Contract Nurse / Temporary Employee

Start date:_____

Stop date:_____

*Note for ALL users: Omnicell access will be completed **after Meditech access paperwork has been completed** and is filed by Information Services. If you have questions, contact your manager.*

Internal Pharmacy use only: Date received:_____ Date completed:_____ By:_____

Date Meditech Received:_____ Meditech ID:_____ Meditech mnemonic:_____

Omnicell Level: _____ MagCard ID:_____ Access Restricted: _____

User ID mapping done by:_____

Omnicell Level Change Date: _____ From:_____ To:_____

Name Change Date: _____ From: _____ To: _____