HSP 03-09

Attachment A

AUTOMATED MEDICATIONS STORAGE AND DISTRIBUTION DEVICE (AMSDD) ACCESS FORM

1. USER INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	LAST 4 SSN

ASSIGNED LOCATION(S)

2. EMPLOYEMENT STATUS

☐ TEMPORARY (*INCLUDES REGISTRY*) SEPARATION DATE: _____ *required*

☐ PERMANENT

3. POSITION

☐ NURSE
- ☐ STAFF
- ☐ SUPERVISOR
- ☐ GRADUATE TECHNICIAN (GNT)
- ☐ INSTRUCTOR/STUDENT/VALOR (NO CONTROLLED SUBSTANCES)

☐ PHYSICIAN
☐ RESPIRATORY THERAPIST (LIMITED ACCESS, NO CONTROLLED SUBSTANCES)
☐ NARCOTIC INSPECTOR (WITNESS ONLY)
☐ PHARMACIST
☐ PHARMACY TECHNICIAN
☐ UNLICENSED ASSISTIVE PERSONNEL (UAP) (LIMITED ACCESS, NO CONTROLLED SUBSTANCES)
- ☐ Administers medications (Scope of medication administration is required)
- ☐ Does not administer medications

☐ DENTAL INTERN (LIMITED ACCESS)

☐ OTHER _____

4. AUTHORIZATION and COMPETENCY

By signing below the USER's Supervisor authorizes the USER access to AMSDD and certifies that the USER has completed all required training, has scope of practice if applicable, and is competent in AMSDD operation and procedures. Copies of TMS Omnicell Medication Administration Training Certificate, Scope if applicable and competency must accompany this authorization request.

SUPERVISOR SIGNATURE PRINT NAME OF SUPERVISOR DATE

5. PASSWORD SECURITY STATEMENT

Below is your User ID and Initial Password for the AMSDD. They are required to access medications from the AMSDD in your assigned area and/or allow you to witness an inventory count. The first time you access the AMSDD you will need to enter a new password. It is your responsibility to ensure you password is kept safe and secure and compliance with HEALTHCARE SYSTEM POLICY (HSP) NO. 00-21 AUTOMATED DATA PROCESSING SECURITY PROGRAM. You are accountable for all transactions performed under your credentials. Transaction records will be archived for inspection and audit.

I understand and agree to keep my password safe and secure and to not share it with any other individual. I understand that sharing my password is considered an egregious violation of VA policy and may result in administrative action and loss of access.

AMSDD USER SIGNATURE DATE

6. SYSTEM ADMINISTRATOR USE ONLY

USER ID		DATE
	AUTHORIZED/VERIFIED BY: _____ ☐ TMS Omnicell Medication Administration Training Certificate ☐ Competency Form ☐ Scope of Medication Administration (only required for UAPs to administer medications)	