ACUDOSE SECURITY AGREEMENT FAX TO: 512-544-4431

PRINT Last Name First Name Meditech 3/4 user ID Position Unit

Please read the statement below and sign to verify that you have read and understand it:

I understand that the signature of the individual administering **a controlled substance to a patient must be documented in the permanent controlled substance record that is maintained by the pharmacy. The AcuDose-Rx system maintains the permanent records therefore the person removing the medication from the cabinet must be the one administering the medication unless additional paperwork is used in conjunction with the electronic documentation.**

I understand that my user ID and password are my LEGAL electronic signature and will be used to track all of my transactions on the system and will be permanently attached to those transactions with the time stamp and date. These records will be routinely audited against patients' chart records by the pharmacy to assure proper usage. The records will be maintained and archived as per SDMC policies and will be available for inspection by the Drug Enforcement Agency (DEA) and the Texas State Board of Pharmacy.

I am responsible for maintaining the confidentiality of my user ID and password and will be held accountable for ALL transactions performed with this User ID. Unauthorized use of another user's password will lead to corrective action up to and including discharge.

________________________________ ______________________

New User's Signature Date

TO BE COMPLETED BY SUPERVISOR/HOUSE SUPERVISOR/AUTHORIZING INDIVIDUAL

CIRCLE type of user and include term of usage if needed; passwords expire every three months.

Nurse Charge CRNA MD Permanent access, password expires every three months

Technician (LD, RAD) Permanent access, Medication handling/No controlled substances

Agency/AAS Nurse Access expires on ___________ (not to exceed 6 months)

Contract/Travel Nurse Access expires on ___________ (length of contract)

Nursing Student Access expires on ___________ (end of present rotation)

Nursing Instructor Access expires on ___________ (end of present rotation)

I have verified the credentials of the above named person and I authorize access to the following AcuDose cabinets:
Circle all areas of access that should be granted.

5NW 5E 4W 4E 3E LD INSY NSY 2E ICU OR PACU AAI EP ED DREC RAD REHAB

__________________________ _______________________ _____________

Authorizing Signature/Position Printed Name Date

FOR COMPLETION BY PHARMACY

User added to AcuDose by ____________________________ Date ______________ Notified/Emailed ________________