Baton Rouge General

CONFIDENTIAL AUTOMATED DISPENSING SYSTEM (ADS) PASSWORD VERIFICATION STATEMENT

This form contains information related to your USER ID and PASSWORD for the ADS. Your USER NAME and PASSWORD will be used to access patient medication on your assigned nursing units. It is your responsibility to keep your password secret (secure). You will be accountable for all transactions performed under this USER ID and PASSWORD.
(Note: You will be prompted to change your PASSWORD every 90 days as an added security measure.)

USER SECTION

Please read the following statement and sign below to verify that you have read and understand the statement.

I understand that my user code will be my electronic signature for all transactions to the ADS, and no other retrievable record of my password exists. It will be used to track all of my transactions on the ADS, and will be permanently attached to those transactions with a time-stamp and date. These records will be maintained and archived as per the policies of the hospital, and will be available for inspection by the Drug Enforcement Agency (DEA) and the State Board of Pharmacy, as is presently done with my handwritten signature for 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(s).

_____ _____
PRINT Name of ADS User Last 4 Digits of SSN

_____ _____/_____/_____
Signature of ADS User Date

*When logging on to the ADS cabinet, your "USER LOGIN" is the first four letters of your last name followed by the last four digits of your Social Security Number (e.g. Jane Yellow's User Login would be "YELL6789"). Your initial password is the last 4 digits of your Social Security Number and will expire immediately, requiring you to select a new password.

SUPERVISOR SECTION

❑ **PLEASE CHECK IF APPLICABLE – No Controlled Substance Access**

_____ _____/_____/_____
Signature of Education/HR Representative or Unit Manager Date

Please circle the nursing **area(s)*** for which access is being requested for this user:
***Please note that employee will have access to all units in the area selected.**

AREA 1: 2E / 2W 3E / 3W PTA2 PTA3 PTA4 PTB4 4E / 4W 5E / 5W BHU

AREA 2: ICU-BB CICU SICU PACU-BB/MC ER-MC ER-BB BURN

AREA 3: PEDS PICU NICU LDRP PTB3

AREA 4: PACU, SDS, CVRA, OR – Areas at BOTH FACILITIES

AREA 5: PROMISE

Please circle the appropriate selection(s) describing employee job description:

RN/LPN Resource Pool RN Student Nurse Contract Nurse Promise Nurse

House Supervisor Nurse Manager Charge Nurse Educator CRNA Pharmacist

Pharmacy Tech/Student Respiratory Therapist Promise Respiratory Therapist Other:_____

Contract Nurse: Contract Expires:____/____/____

Nursing Instructor: Expiration Date:____/____/____ School Affiliation:_____

Student Nurse: Expiration Date:____/____/____ School Affiliation:_____

PHARMACY SECTION

(Assigned by Pharmacy): _____(Pharmacy Initials)