A primary access code for the ***Automated Medication Dispensing System*** (AMDS) is used to access patient medications on nursing units or in official patient care areas. Access is allowed to the AMDS via a User Identification (first initial and last name, up to 10 characters) plus a Personal Identification Number (P.I.N.).

AUTOMATED MEDICATION DISPENSING SYSTEM ACCESS FORM

Employee Name (Please Print: Last Name, First Name)		**Unit**
Classification	**Title**	**Employee Number**

The P.I.N. number or access code is unique to an individual and is completely confidential. It should not be shared between individuals. If the P.I.N. number is forgotten, access must be re-set by the pharmacy.

Please read the statement below and sign at the bottom of this form to verify that you have read and understand your responsibility:

I understand that the combination of my user name and my access code (P.I.N.) will be my electronic signature of all transactions in the AMDS. It will be used to track all of my transactions with a time stamp and date. These records will be maintained and archived as per the policy of John H. Stroger Hospital of Cook County and be available for inspection by the Drug Enforcement Administration (D.E.A.) and the Illinois Department of Professional Regulations (IDPR), as was previously done with my handwritten signature for controlled substance records.

I agree to abide by all policies, rules and procedures that govern access and use of the AMDS.

I understand and agree that I will not give my personal access code to any other individual. To share my access code is a violation of hospital policy and is subject to disciplinary action.

Employee Signature **Date** **Phone Extension or Pager**

Permissible Access Areas

(1)_____ **(2)** _____ **(3)** _____ **Nursing Management** _____

(4)_____ **(5)**_____ **(6)** _____ **Pharmacy Management**_____

Supervisor's Signature Authorizing Access **Date** **Supervisor's Printed Name** **Phone / Pager**

TO BE COMPLETED BY PHARMACY ONLY

Received By Date Pended By Date

APPENDIX-A

CCHHS Computer Sign-On Request Form

Nursing

Network: _____

Cerner: _____

Other:

A. ☐ Add ☐ Change access or personal info ☐ Inactivate ☐ Re-new

B. Last _____ First _____ MI _____ Healthcare Credentials (e.g., RN, LPN, CRNA, CNS)

Cook County ID badge # or last 2 of SSN _____ APN NPI _____ APN Pager _____

State License # _____ APN DEA _____

With my signature, I affirm that I received, read, and will abide by the Information Security Rules of the Behavior.

_____ / _____ / 20____ Date _____ Firm/Agency, if non-County

User's Signature _____ Position or Title _____

C. Primary Location (check one)

☐ ACHN ☐ Cermak ☐ Core Center ☐ J H Stroger ☐ Juv Det ☐ OFH ☐ Provident ☐ Public Health

Medical Department or ACHN Site or Public Health Site _____

D. Access Duration

_____ /_____ / _____ Start Date -- _____ /_____ / _____ End Date

(End date for temporary users such as students, volunteers, residents & contractors)

☐ County Employee *(No end date)* EMP# Req _____

E. Special Access ☐ Cook County email ☐ Internet ☐ VPN ☐ AcuityPlus ☐ ANSOS

☐ Bridge same access as :_____ ☐ Zeiss same access as :_____

☐ Clairvia ☐ PyxisES ☐ Teletracking same access as :_____

F. Cerner **Check 1** below or request access the same as (existing user) _____

- ☐ Correctional Medical Tech
- ☐ Correctional Medical Tech w/Rad Order
- ☐ ED Nurse
- ☐ Nurse Instructor
- ☐ Nurse LPN Amb
- ☐ Nurse LPN InPt
- ☐ Nurse LPN InPt Cermak
- ☐ Nurse LPN InPt OB
- ☐ Nurse RN Amb
- ☐ Nurse RN Amb Diabetes Team
- ☐ Nurse RN Amb OB
- ☐ Nurse RN InPt OB
- ☐ Nurse RN Infusion Center
- ☐ Nurse RN InPt Orders
- ☐ Nurse RN InPt Orders Cermak
- ☐ Nurse RN InPt Orders JTDC
- ☐ Nurse RN Mgmt/Admn 2
- ☐ Nurse RN Mgmt/Admn Amb
- ☐ Nurse RN Mgmt/Admn InPt
- ☐ Nurse RN Mgmt/Admn InPt Cermak
- ☐ Nurse RN NICU
- ☐ Nurse RN Ophthalmology
- ☐ Nurse RN Public Health
- ☐ Nurse RN Public Health Supv
- ☐ Nurse RN Specialty Service
- ☐ Nurse RN Specialty Service PowerNote
- ☐ Nurse Student APN Anesthetist
- ☐ Nurse Student RN
- ☐ Nurse Student RN/APN
- ☐ Nursing Medical Assistant
- ☐ Nursing Medical Assistant OB
- ☐ Nursing Medical Assistant Ophthalmology
- ☐ Nursing Medical Assistant PowerNote
- ☐ Nursing PCA/CNA Amb
- ☐ Nursing PCA/CNA InPt
- ☐ Nursing Telemetry Tech
- ☐ Nursing Unit Clerk Amb
- ☐ Nursing Unit Clerk Cermak
- ☐ Nursing Unit Clerk InPt
- ☐ SurgiNet OR Manager
- ☐ SurgiNet OR Nurse 1
- ☐ Utilization Management
- ☐ Utilization Management Supv
- ☐ QA/UR

Cerner **FirstNet** ED: ☐ PROV ☐ ADULT ☐ PEDS ☐ TRAUMA

Share Drive Request (please input path):

G. Request authorized by (Department Chair or Director)

Signed _____ Print Name _____ Phone or pager _____ Title

* Signed _____ Print Name _____ Phone or pager _____ Title

Incomplete forms will NOT be processed. Deliver to the Stroger Hosp HIS Help Desk, room 2650 or email the form to cch-helpdesk@cookcountyhhs.org. Call 312-864-HELP, for status after 2 Business days.

Rev. JAN 2018

CCHHS NON-EMPLOYEE BADGING FORM

A separate form must be completed for each contractor requesting a badge. Click on 'Fill & Sign' to enter the required information. All information is required. Physical signatures are required.

Section 1 - This section is completed by Company/Organization/Institution Name (Company)
Complete this section for each employee your company provides to CCHHS. Attach separate sheet(s) for additional Information. Send this form, the job description and any additional documentation via e-mail to the CCHHS Department Head/Manager/Designee responsible for managing the contract with your company.

Contractor Last Name

Contractor First Name

Contractor Company Name

CCHHS Location (Drop Down Menu

Level of Patient Contact (Drop Down Menu)

Contractor Company Job Title

CCHHS Department

Description of work to be done. Attach a job description provided by the Contractor Company.

Contractor E-Mail for Correspondence

Contractor Contact Phone Number

Section 2 - CCHHS Access Level Granted - This section MUST be completed by the CCHHS Head/Manager/Designee responsible for managing the contract. Up to seven (7) locations can be selected for access for a badge holder. If less than seven (7) locations, leave additional slots blank. **Once CCHHS Head/Manager/Designee completes and signs this document, return it and all attachments to Company.**

Location 1

Day(s) of Week/Time

Location 2

Day(s) of Week/Time

Location 3

Day(s) of Week/Time

Location 4

Day(s) of Week/Time

Location 5

Day(s) of Week/Time

Location 6

Day(s) of Week/Time

Location 7

Day(s) of Week/Time

CCHHS Head/Manager/Designee Name & Title

Phone #

CCHHS Head/Manager/Designee Department

CCHHS Head/Manager/Designee E-mail

CCHHS Head/Manager/Designee Signature

Date

This section is completed by CCHHS HR

Type of Badging Process Initiated

- ☐ Contractor
- ☐ Other

Type of Badge

- ☐ New
- ☐ Renewal
- ☐ Replacement/ Cashier Receipt

Orientation Attendance Required

- ☐ Yes
- ☐ No

Professional License Type & Number (Or N/A)

PSV Expiration Date

Badge Id #

Badge Holder Extension/Pager/Cell

Badge Expiration Date

HR Approver Name & Title

HR Approver Signature

Date

Section 3 - BADGE HOLDER ACKNOWLEDGMENT - This section is signed when a badge is issued.

I acknowledge the receipt of this security access card and all rules and regulations regarding its use. No access is to be given to unauthorized personnel. I will be held responsible for reporting the loss, theft or misuse of this card. The replacement cost of the card must be paid to the cashier prior to receiving a new card. To receive a new card, a receipt from the cashier with a new Non-Employee Badging form completed and signed by the CCHHS Approver of my work area must be provided to the CCHHS HR department. Any misuse of this card may result in termination of access to all CCHHS facilities.

Badge Holder Signature

Date

HR Approver Name & Title

HR Approver Signature

Date