FAQ

Completing the Automated Dispensing Machine (Omnicell) User I.D. Request Form (Nursing Students)

In order to obtain a User ID for the automated dispensing cabinets (ADC), you **must have completed SCM training and have an SCM User ID**. If you are in the process of obtaining an SCM User ID (e.g., have signed up for a course), you can still apply for an ADC User ID.

Your ADC User ID will be active for the duration of your practice education placement at PHC. It will expire upon completion of your placement. If you have subsequent placements at PHC, you will need to reactivate your User ID for each placement by completing another request form.

User IDs can take **at least 3 business days** to initiate/reactivate so please send in your form as soon as your placement has been confirmed.

New Account Applications

1. Check "New Account".
2. Enter you last, first and middle names.
3. Check "Nursing Student" as your job title.
4. Indicate the SITE and NURSING UNIT of your placement.
5. Provide your email address.
6. Enter your SCM User ID.
7. For "Effective Date" and "Expiry Date", enter the start and end dates of your placement.
8. Your supervisor DOES NOT sign the form. Leave blank.
9. Sign and date the request form.

Re-activate Existing Account

1. Check "Re-Activate".
2. Enter you last, first and middle names.
3. Check "Nursing Student" as your job title.
4. Indicate the SITE and NURSING UNIT of your placement.
5. Provide your email address.
6. Enter your SCM User ID.
7. Enter the User ID for your existing ADC (Omnicell) account, if known.
8. For "Effective Date" and "Expiry Date", enter the start and end dates of your placement.
9. Your supervisor DOES NOT sign the form. Leave blank.
10. Sign and date the request form.

DO NOT FAX the form to SPH Pharmacy. Submit the completed form to your clinical instructor, who should forward the form to the Student Placement Coordinator for approval at wchang@providencehealth.bc.ca (fax 604-806-9315).

Rehabilitation and Tertiary Mental Health Pharmacy Department

AUTOMATED DISPENSING MACHINE (OMNICELL®) USER I.D. REQUEST FORM

PART A: **USER I.D. ADD/DELETE/CHANGE REQUEST**

This form should be completed by the **Supervisor (OL/CNL/CNE/Department Head)** of the person whose account is to be Added, Deleted or Changed.
***Please allow at least 3 working days for any request to be processed*.**

PLEASE USE CAPITAL LETTERS **FIELDS MARKED * ARE REQUIRED**

***Select one:**

[ ] NEW ACCOUNT [ ]CHANGE **[ ] RE-ACTIVATE** **[ ] DELETE** **[ ] NAME CHANGE**

***Last name :**	***First name :**	***Middle name:**

***Job title:**	**[ ] RN**	**[ ] Employed Nursing Student**
[ ] MD (specialty:_____)	**[ ] LPN**	**[ ] RPN**
[ ] MD Locum	**[ ] Nursing Student**	**[ ] Other**
[ ] CNL/CNE	**[ ] Nurse Instructors**	

***Site: [ ] Holy Family [ ] Parkview [ ] Alder**	***Nursing Unit:**	**Local:**
Email:		
***SCM User I.D.:**	***Existing User I.D.:** *(if known, for Re-activate/Delete/Change requests)*	
***Effective Date:**	**Expiry Date:** *(*Required for term contracts)*	
***Supervisor(OL/CNL/CNE/.Department Head) Name:**	***Supervisor's Local:**	***Supervisor's Signature:**

***PART B:** **STATEMENT OF CONFIDENTIALITY**

To be completed by all new employees to obtain network access. Please read and sign to indicate you understand the following: I agree to access patient information as per hospital policies. In particular, I understand that: the username issued to me identifies me to the Automated Dispensing Machine and that I am fully responsible for all transactions made with reference to this identity; I will maintain the confidentiality of my username and password and will not reveal it to others; I will change my password every 90 days or, should it become known to others, I will change it immediately; My username will expire on the date indicated above (applies to term assignments only). If I am to continue at the hospital beyond this date I understand that it is my responsibility to reapply for continued use of the system (applies to term assignments only).

***EMPLOYEE SIGNATURE:**

***DATE:**

Once signed, please send this form via fax (604-322-2652) or internal mail to:
Pharmacy Department – Holy Family

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