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Kaiser Permanente – West Los Angeles Medical Center

## **Request for Pyxis Device User Access**

Approver's Signature: \_\_\_\_

All requests are processed within 72 hours of receipt. All sections within the two pages must be completed for new and current staff to avoid delays. Hiring Manager/Dept Administrator is the Primary Person whom this User reports to and will be contacted for verification of this form.

1. Select type of access:								
TYPE OF PYXIS DEVICE USER ACCESS								
☐ New	New employees - access to Pyxis locations							
☐ Delete	Remove Pyxis access due to Termination or Transfer to non-Pyxis location/other hospital							
☐ Change/Transfer	Change/Transfer							
2. Fill in user's information completely and legibly. Do not use nicknames.  First Name Middle Name Last Name NUID User's Contact Phone #								
First Name	Middle Name	Last Name	Last Name		User's Contact Phone #			
3. Select appropriate user's job description:								
Job Description [Pharmacy-Assign Title : Privilege Template]								
-	-	g RN : Charge/Relief RN]						
Staff RN [RN : Staff R		Certified Registered Nurse Anesthetist [CRNA : CRNA]						
Float RN [Float RN : I		☐ Pharmacy Technician / Intern [Pharmacy Tech : Pharmacy Tech						
OR Staff RN [OR RN Licensed Vocational N			cist [Pharmacist : Pharma	=				
Educator / CNS [Educ	NS1		ogy Technologist [Rad Te	ech: Rad Tech]				
		=	Respiratory Therapist					
DA / ADA / Manager / CME / House Supervisor / CNE / Director [Manager : Manager]  [Resp Care Practitioner : Respiratory Therapy]								
Time-Dependent Staff Positions (Contract Dates REQU			r Access)	Contract START	Date: Contract	END Date:		
☐ Traveler RN / Registry RN [Traveler RN : RN Traveller]								
O.R. Traveler RN / C								
Clinical Nurse Instru	or : Clinical Instructor]							
4. Select appropriate Home Access area: Check only 1 box per user **								
Home Unit [Pharmacist-Assigned Pyxis Areas] ** all other area access shall be granted as "Activate User" for 24-hour use only								
☐ ED [Select Area: EI		ET DSurg, ET PACU, Pain Management, WT PAC						
	<del></del>	[Select Areas: ET Periop, WT Periop]						
2A [Select Area: 2A		CRNAs / Anesthesiologists						
2SE and 2SW [Salar	<u> </u>	[Select Area: ENDO, ET Periop, L&D, OR, and WT Periop]						
☐ 2SE and 2SW [Select Area: 2S]		<u> </u>	ET and WT Operating Room [Select Area: OR]					
☐ ICU [Select Areas: ICU]			Respiratory Therapists [Select Area: 2A, 2S, 5W, 5E, EDWL, ICU]					
L&D [Select Areas: L&D]		<del></del>	Bronchoscopy [Select Areas: BRONCH]					
☐ FCC [Select Areas: FCC]		<u> </u>	GI [Select Areas: ENDO]					
☐ NICU [Select Areas: NICU]		<u> </u>	☐ Interventional Radiology [Select Areas: RAD]					
5A and 5B [Select Areas: 5W]		<u> </u>	Educators and CME [Select Areas: TEST]					
☐ Pharmacy staff [All	☐ House St	☐ House Supervisor [All Areas]						
5. Obtain Approval from Hiring Manager, Department Administrator, Assistant Dept Admin, CME, or Nursing Director:								
Approver's Printed Name: Approver's Title:								

6. User must read and sign the Pyxis User's Agreement section (page 2 of 2) before IP Pharmacy will process this request.

Approver's Contact Information: OFFICE PHONE: \_\_\_\_\_\_PAGER/CELL: \_\_\_\_\_

Approval Date:

Kaiser Permanente – West Los Angeles Medical Center Request for Pyxis Device User Access

## **PYXIS USER'S AGREEMENT**

## My Accountability for Pyxis Device Access

I will use my NUID as the User ID, Initial Password, and a fingerprint for initial access to the Pyxis MedStation Rx System. My NUID and fingerprint will be used to access patient medications on assigned nursing unit(s). The first time I access the Station or Console, I will be required to enter a new and confidential password. It is my responsibility to keep my password secret. I will be held accountable for all transactions performed by this NUID and fingerprint. These records will be maintained and archived according to policy and procedure.

I understand that to maintain the integrity of my electronic signature, I must not give my password to any other individual. Unauthorized access, release or dissemination of my access information may subject me to disciplinary action. Should I have any suspicion that my personal password has become known to another individual, I will immediately report such to my Department Administrator/Assistant DA/Manager/ Supervisor and request a password change through the Inpatient Pharmacy.

If I have any difficulties with my fingerprints after trying the various methods and all 10 fingers, I will escalate this issue to my Department Administrator/Manager.

I have read and understand the significance of the PYXIS PROCEDURES- AUTHORIZATION OF

EMPLOYEE NAME (Print)

EMPLOYEE SIGNATURE

DATE

WITNESS SIGNATURE

DATE

SECURITY ACCESS policy (mcw #2248) and agree to abide by it.

INPATIENT PHARMACY USE ONLY					
Confirmed New Pyxis User's ID:					
Contact person's name:	Date of notification:				
☐ Form is complete, access is approved ☐ Incomplete form, access is denied and referred back to Approver for re-issue  Pharmacist Initials: Date & Time:					

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