Monroe Livingston Region Program Agency

Division of Prehospital Medicine, University of Rochester
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ADVANCED LIFE SUPPORT

EMS Provider Medication Access Station Request

Provider Name: _________________________________ **NYS EMT#:** __________________

Provider Level: _________________________________

Agency: ____ **Request Date:** _________________

ALS Chief E-Mail Address: ____

This request shall be considered valid ONLY when received by the hospital directly from the Program Agency.

For Pharmacy Use Only

Password Confidentiality Agreement

My User ID and password are used to access patient medications and supplies needed to restock after patient use. The first time I access the medication station, I may be required to enter a new, confidential password. It is my responsibility to keep my password secret. I will be accountable for all transactions performed under this User ID and password. My User ID and password combination will be used to track all of my transactions on the system, and will be permanently attached to those transactions with a time and date stamp. These records will be maintained and archived per the policies of the hospital listed below, and will be available for inspection by Federal and NYS regulatory agencies as required by law. I also understand that to maintain the integrity of my electronic signature, I must not give this password to any other individual.

By signing below I acknowledge receipt of my user ID and temporary password and agree to the terms above.

____ _______________
EMS Provider Signature Date

____ HH Unity
Pharmacy Representative (print and sign) RGH SMH

To Be Completed by Hospital Pharmacy Staff

Provider Name: _______________________________________ **NYS EMT #:** ____________

User ID: _________________________________ **Temporary Password:** ________________

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