

ELLIOT PHARMACY SERVICES
ACUDOSE SECURITY ACCESS FORM

Please complete the following form for access to the AcuDose Medstation

NAME: _____

ADDITION

DELETION

CHANGE

DATE: _____ USER ID _____

(Example: your nursing unit followed by your 3 initials)

NURSING UNITS TO ACCESS: _____

CHECK ONE OF THE FOLLOWING:

FACULTY RN FLOAT CHARGE/CLINICAL LEADER

IF TRAVELER, PASSWORD EXPIRATION DATE: _____

EMPLOYEE SIGNATURE: _____

DEPT DIRECTOR/CLINICAL LEADER: _____