

Nurse Instructor PYXIS Access Request

Please complete all of the following information.

Instructor Personal Information		School Information	
Legal Last Name:		School/Facility Name:	
Legal First Name:		School/Contact Name:	
Middle Initial:		Phone/Ext:	
Email:			

Access Specifics			
Are you a current Providence Employee? (circle one)		Yes	No
Have you had access to Providence Pyxis access in the past? (circle one)		Yes	No
If you have had previous access, what was your login ID?			
Access Start Date:		Access End Date:	
Please select the Providence Location where you will be a instructor:	<input type="checkbox"/> Providence St. Peter Hospital <input type="checkbox"/> Providence Centralia Hospital <input type="checkbox"/> Providence Medical Group (specify clinic) _____		

Instructor Acknowledgement & Signature		
By signing this access request, I acknowledge that all information contained within Providence Health Systems is considered confidential and should only be shared with others for business related purposes relative to my role. I accept responsibility for taking appropriate measures to secure my login and to keep my password private and follow Providence policies for medication administration and the use of Pyxis.		
Instructor	Signature:	Date: