Pharmacy Examining Board

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AUTOMATED TECHNOLOGY FINAL CHECK PILOT PROGRAM REPORT

COMPLETED REPORTS MUST BE SUBMITTED TO THE BOARD ON OR BEFORE JULY 31 OF EACH YEAR.
PLEASE NOTE: ADDITIONAL DETAILS MAY BE REQUESTED BY THE BOARD ON A CASE BY CASE BASIS.

DBA NAME OF PHARMACY: (This must be the name on the pharmacy license.)	**PHARMACY TELEPHONE:**	**PHARMACY WI LICENSE NUMBER:**
PHARMACY ADDRESS (pharmacy location to which the variance applies)**:** number, street, city, zip code		
MANAGING PHARMACIST:	**EMAIL:**	
PHAMACIST RESPONSIBLE FOR THE AUTOMATED DISPENSING TECHNOLOGY:	**EMAIL:**	

OVERALL ACCURACY RATES FOR PHARMACY

FOR TIME PERIOD ☐ **_____/_____/_____ TO _____/_____/_____**
Month Day Year Month Day Year

Total number of doses checked by the automated dispensing technology					
Total number of doses checked by pharmacist as part of quality assurance audit					
Errors identified by prior to leaving the pharmacy					
	Wrong Drug		Wrong quantity		
	Wrong Dose		Omitted medication		
	Wrong Dose Form		Expired Dose		
Errors identified after leaving the pharmacy					
	Wrong Drug		Wrong quantity		
	Wrong Dose		Omitted medication		
	Wrong Dose Form		Expired Dose		
Total number of errors that reached the patient and caused harm					
Number of pharmacist hours reallocated to other patient care activities					

Description of reallocated activities

I/We declare that the foregoing statements and attached corresponding documents are true and correct to the best of my/our knowledge and belief.

_____ _____ _____
Pharmacist Responsible for Automated Dispensing Technology Signature | WI License Number | Date