**WORKPLACE ASSESSMENT TOOL**

For the week of **January 14, 2019 through January 20, 2019**, please provide the following information:

### PERSONNEL ANALYSIS

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Is your staffing adequate to allow your pharmacy to safely and efficiently serve the public? If not, what suggestions regarding the staffing of your pharmacy would you make?

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### PRESCRIPTION ANALYSIS

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### EQUIPMENT AND WORK CONDITIONS

Please check each of the following that are in your pharmacy:

- Pill counter
- Baker cell machine
- ScriptPro machine
- Scan verification system
- Regularly scheduled breaks for non-pharmacists
- Regularly scheduled breaks for pharmacists
- Direct telephone for physicians
- Voice mail for refills
- Drive-thru window
WORKPLACE ASSESSMENT TOOL

For the week of April 01, 2019 through April 07, 2019, please provide the following information:

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Is your staffing adequate to allow your pharmacy to safely and efficiently serve the public? If not, what suggestions regarding the staffing of your pharmacy would you make?

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EQUIPMENT AND WORK CONDITIONS

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- Voice mail for refills
- Drive-thru window
What equipment or work condition(s) would improve the efficiency and safety of your pharmacy?

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SUGGESTIONS FOR IMPROVEMENT OR COMPLIANCE

If the workflow of your pharmacy could be improved, what would your suggestions be?

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Are you and all of your other pharmacists counseling every patient for whom counseling is required or would be advisable? If not, what suggestions would you make to improve your pharmacy’s compliance with the counseling requirements?

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Do you have any other suggestions that would improve the efficiency and safety of your pharmacy?

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I have reviewed this Workplace Assessment Tool and have the following comments, observations, or suggestions (if any).

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Pharmacist Signature ____________________________________ Date __________________
I have reviewed this Workplace Assessment Tool and have the following comments, observations, or suggestions (if any).

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Pharmacist Signature __________________________ Date ________________

I have reviewed this Workplace Assessment Tool and have the following comments, observations, or suggestions (if any).

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Pharmacist Signature __________________________ Date ________________

ACCOMPANYING DOCUMENTATION

Please have ready the counseling logs for the specified time for inspector review.

I hereby affirm under penalty of perjury and discipline against my and/or my pharmacy’s license that the above answers are true and complete.

SIGNATURE __________________________ DATE ________________

NAME OF MANAGING PHARMACIST (PRINT)