WORKPLACE ASSESSMENT TOOL

For the week of ***January 18, 2016 through January 24, 2016***, please provide the following information: wk201603

PERSONNEL ANALYSIS

	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Total Pharmacist Hours							
Total Technician Hours							
Total Clerk Hours							
Total Man-Power Hours							
Total Hours Open							

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?

_____
_____
_____
_____
_____
_____
_____

PRESCRIPTION ANALYSIS

	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
New Prescriptions							
Refill Prescriptions							
Total Prescriptions							

Of the Total Prescriptions above, please categorize them as follows:

	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Cash Prescriptions							
3rd-Party Prescriptions							
Compounded Prescriptions							
Parenteral Prescriptions							

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 ***September 05, 2016 through September 11, 2016***, please provide the following information: wk201636

PERSONNEL ANALYSIS

	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Total Pharmacist Hours							
Total Technician Hours							
Total Clerk Hours							
Total Man-Power Hours							
Total Hours Open							

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?

_____
_____
_____
_____
_____
_____
_____

PRESCRIPTION ANALYSIS

	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
New Prescriptions							
Refill Prescriptions							
Total Prescriptions							

Of the Total Prescriptions above, please categorize them as follows:

	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Cash Prescriptions							
3rd-Party Prescriptions							
Compounded Prescriptions							
Parenteral Prescriptions							

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

What equipment or work condition(s) would improve the efficiency and safety of your pharmacy?

_____
_____
_____
_____
_____
_____
_____
_____
_____

SUGGESTIONS FOR IMPROVEMENT OR COMPLIANCE

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

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?

_____
_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
Pharmacist Signature Date

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
Pharmacist Signature Date

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
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)