Omnicell Weekly Cycle Count Verification Form

Omnicell Location: ____ Month: _______________________ Year: ______________

Week	RN Signature	RN Signature
Week 1 Date Completed _____/____/_____		
Week 2 Date Completed _____/____/_____		
Week 3 Date Completed _____/____/_____		
Week 4 Date Completed _____/____/_____		
Week 5 Date Completed _____/____/_____		

Two signatures are required to complete cycle counts on ALL control substance and keys stored in the Omnicell excluding those contained in an OmniDispenser. All discrepancies will be resolved timely as defined by hospital policy. Completed monthly cycle forms will be retained on PCA per policy.