ASSOCIATION OF ALEXANDRIA RADIOLOGISTS, PC

Complete one form for each user.

PACS ACCOUNT REQUEST FORM

*(Fields with an * are required)*

*First Name: _____

Middle Initial: _____

*Last Name: _____

*Check one: ☐ Physician ☐ Clinical Staff ☐ Office Staff

*Group Name : _____ or Solo Practice: ☐

*Street Address: _____

Address 2: _____

*City: _____

*State: _____ Zip: _____

*Phone Number: (_____)_____

*Fax Number: (_____)_____

*Email Address: _____

Office Manager or Practice Administrator:

Name: _____

Email: _____ *(for critical updates regarding AAR Services)*

Email Notification: Would you like to receive email notification when orders assigned to you are ready for viewing?
☐ Yes ☐ No

Training: Would you like to request a training session?
☐ Yes ☐ No

Fax completed form to the PACS Support Team at 703.321.3300

A member of the team will contact you with your user name and password and schedule a training session, if requested. If you have a question please contact us at PACSsupport@alexandriaradiology.com or call 703-824-3240.