INOVA HEALTH SYSTEM
SYSTEM ACCESS REQUEST FORM (SARF)
PROVIDERS, RESIDENTS & OFFICE STAFF ONLY
Training is required for access to Inova Clinical Systems.

Request Number: _____

Email completed SARF, Access Agreement Form and Acceptable Use Form to SARF.MAILBOX@INOVA.ORG. Upon receiving a completed SARF a request number will be provided. The SARF will be returned if required fields are not completed; processing could be delayed.

Legal Last Name: _____ **Legal First Name:** _____ **MI:** _____ **Preferred Name/Nickname:** _____

Group Practice Name: _____ **Primary Inova Facility:** _____ **Provider #:** _____

Office Address: _____ **Office Phone:** _____ **Fax Number:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Email Address:** _____

Date of Birth: _____ **(mm/dd/yy)** **Gender:** _____ **(M or F)** **Last 4 digits of Social Security Number:** _____

Required for Physician/Resident/NP/CNM/PA

DEA #: **Medical License #/State:** **Individual NPI #:**

Credentials or Job Title:

☐ MD ☐ DO ☐ NP ☐ CNM ☐ PA ☐ RN Job Title:

Request Type: ☒ New Access ☐ Update Access ☐ Deactivate Access Effective Date

Please choose the system access needed.

☒ **Network Access (required for EPIC and Remote PACS)**

☐ **EpicCare***
(Inova Credentialed Providers & Community Connect office staff)

☒ **EpicCare Link***
(Inova Non-credentialed Providers, Physician office staff, Third-party Billers)

Has Epic training been completed? ☐
Date training completed

If 3rd Party Biller please provide:
Company Name:

Remote Access to Epic & Remote PACS

☒ Remote Citrix Access **(required for external access to EPIC and Remote PACS)**

Effective 06/26/2015, soft tokens will be issued to providers and office staff. Email address is **required** for processing requests.

☐ Replacement Token
It you currently have a network ID please provide

Applications below are available to credentialed physicians only

☐ Remote PACS

*** Email LearnEpic@inova.org to schedule EpicCare training.**

Specify other system access requirements below or systems that are not listed above:

Additional comments or explanation of business function that requires this access:

Approval Information:

I hereby certify that all information contained on this form is true and complete. Falsified statements are sufficient basis for dismissal.
Physician must sign for office staff and authorizes the following:
I authorize this user within my practice to have Proxy Access to my patients' medical information.

**User requiring access (Print Name)	Signature	Approval Date	Phone #
Approving Physician (Print Name) **(Required)	Signature **(Required)**	Approval Date	Phone #
Authorized Inova Designee or Trainer (Print Name)	Signature **(Required)**	Approval Date	Phone #

****Name and signature required for processing.**

Please scan and send completed form to SARF.Mailbox@inova.org

Revised 06/22/16