Complete one form for each user.

VISION REACH™: a powerful new PACS solution

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.

8001 Forbes Place
Suite 103
Springfield, VA 22151
PACS Support Team (703) 824-3201
PACSsupport@alexandriaradiolgy.com