Identity Proof Verification

Electronic Prescribing of Controlled Substances (EPCS)

Practitioner Name:_____ **Provider ID:**_____

1. Do you have an unrestricted Virginia Medical License (**NOT** a training license)? ☐ **Yes** ☐ **No**
   *If you answer '**No**', please proceed to Question 5. If you answer '**Yes**', please answer Questions 2 - 4.*

2. Please provide your federal DEA registration number associated with your unrestricted Virginia Medical License (if applicable): _____

3. Has your federal DEA Registration or controlled substance license in any state been, or is it in the process of being revoked, suspended, placed on probation, reduced, limited, investigated, modified or relinquished, whether voluntarily or involuntarily, or has your application for a controlled substances registration in any state ever been denied? (to include territories, commonwealths and District of Columbia) ☐ **Yes** ☐ **No**

   If Yes, please explain on a separate sheet.

4. Does your federal DEA Registration allow you to prescribe Schedules 2, 2N, 3, 3N, 4, 5? ☐ **Yes** ☐ **No**

   If No, please explain._____

Complete Question 5 ONLY if you DO NOT have an unrestricted Virginia Medical License

5. By initialing here, you are confirming you have received your institutional DEA number from the IFMC GME office and acknowledge that this number is only for use in caring for Inova Health System patients during your residency/fellowship program duties, and not for any other use.

Initial_____

_____ _____

Practitioner Full Legal Name (Print) **Date**

_____

Practitioner Signature

FOR OFFICE USE ONLY

☐ IFMC Resident/Fellow

☐ MedStar Georgetown Resident/Fellow
- ☐ Orthopedics
- ☐ Plastic Surgery
- ☐ Urology
- ☐ Pulm/CC
- ☐ Pediatrics
- ☐ Emed

☐ UVA Resident
- ☐ Anesthesia

☐ George Washington University Resident/Fellow
- ☐ Emergency Medicine
- ☐ Psychiatry

☐ Children's National Medical Center
- ☐ Trauma
- ☐ Urology

☐ National Capital Consortium Resident/Fellow
- ☐ Orthopedics
- ☐ Gynecology / Oncology
- ☐ Family Medicine
- ☐ Fem Pelvic & Rec Surg
- ☐ Vascular
- ☐ ENT
- ☐ Radiation Oncology
- ☐ Surgery
- ☐ Pulm/CC
- ☐ Medicine
- ☐ Peds
- ☐ TY
- ☐ Anesthesia
- ☐ Psychiatry

_____ _____ _____

Credentialing Office Signature **Name (Print)** **Date**