



Complete ONLY if you have NEVER rotated to an Inova Facility

Graduate Medical Education

Inova Fairfax Hospital Campus

**Identity Proof Verification
Electronic Prescribing of Controlled Substances (EPCS)**

Practitioner Name: _____

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 **non-institutional** 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 a non-institutional Federal DEA number

5. By initialing here, you are confirming you have received your institutional DEA number from the IFHC 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) _____

Practitioner Signature _____

Date _____

FOR OFFICE USE ONLY

Provider ID# _____

IFHC Resident/Fellow

George Washington University Resident/Fellow

MedStar Georgetown Resident/Fellow

Children's National Medical Center

National Capital Consortium Resident/Fellow

University of Virginia

Other Site _____

Credentialing Office Signature

Name (Print)

Date