



PROVIDER RADVISION INSTALLATION REQUEST

Providers requesting access to view on-line images and reports must complete the information requested below. **AFTER COMPLETION, PLEASE FAX THE REQUEST TO 545-1726.**

Installation Request For:	RadVision Images	RadVision Reports	Both	Date of Request: ____ / ____ / ____
Office Contact: _____	IT Contact: _____			
Best Contact Method:	Office Phone	Fax	Cell	Best Contact Method: Office Phone Fax Cell
Contact Number: _____	Contact number: _____			
Practice Name: _____				
Address / Zip: _____				
Phone: _____	Fax: _____			
Internet Connection:	Cable	DSL	Dial-Up	T-I Line Satellite
Windows Version:	2000	XP	Vista	Other _____
Number of Computers: _____	Do you have Administrative Rights? Yes No			

Please List the Names and Titles of the Referring Providers and Office Staff that will need access:

(i.e. Susan Smith, MD, Chip Clark, NP, Linda Jones, PA, Becky Brown, MA, etc.)

Have you ever had RadVision access at another office?

- | | | |
|---|-----|----|
| (1) _____ | Yes | No |
| (First) (Middle Initial) (Last) (Title) | | |
| (2) _____ | Yes | No |
| (3) _____ | Yes | No |
| (4) _____ | Yes | No |
| (5) _____ | Yes | No |
| (6) _____ | Yes | No |
| (7) _____ | Yes | No |
| (8) _____ | Yes | No |
| (9) _____ | Yes | No |
| (10) _____ | Yes | No |

Requested by: (please print name & title) _____

Provider or Office Manager Signature: _____

Please call the RadVision Hotline at 901-6747 if you have any questions or need assistance.

For Radiology Ltd. internal use only:	
PR Support: ____ / ____ / ____	RadVision Specialist: ____ / ____ / ____
(ACT Dbase entry Date)	(RadVision Install Date)