St. Clair County Community Mental Health

Provider Enrollment – Update or Disenrollment for OASIS

(Forward completed forms to helpdesk@sccccmh.org)

Request Details:			
Date of Request:			
Effective Date:		**Termination Date:**	
☐ Enrollment ☐ Update ☐ Disenrollment ***(to be completed when staff has been terminated)*** ☐ Staff does not require a USER ID (log-in) to access OASIS (Community Service Technicians)			
Supervisor Signature:	____________________ *(Signature indicates approval of request)*		

Staff Information:			
Staff Name:		**DOB:**	
Job Title:			
Tasks:			
Provider Credential(s): (Clinical Staff only – i.e., LMSW)			
Work Phone #:		**Work Email:**	
Agency Name:			
Location(s) Name:			

Licensing & Credentialing Information: Please include all applicable information in regard to licensing and credentialing.					
Degree:		**Effective Date:**			
NPI #:		**Effective Date:**			
License Name/Number:		**Effective Date:**		**Exp. Date:**	
License Name/Number:		**Effective Date:**		**Exp. Date:**	
Certification(s):		**Effective Date:**		**Exp. Date:**	
Certification(s):		**Effective Date:**		**Exp. Date:**	

For Psychiatrists & Nurse Practitioners Only:					
DEA #:		**Effective Date:**		**Exp. Date:**	

Additional Enrollments:	
FAS System: (Children's Programs Only)	☐ Add to Functional Assessment System (for CAFAS/PECFAS Assessments)
2FA Selection:	☐ 2-Factor Authentication Token or ☐ 2-Factor Authentication Mobile App

For Data Management Staff Use Only:

☐ Data Management – E-Scribe Set Up

Date & Initials Received by DM Tech: ____________________

Date entered into OASIS System: ____________________

Date e-mail notice was sent to requestor: ____________________