St. Clair County Community Mental Health Authority

OASIS
Optimal Alliance Software Information System

OASIS Enrollment Request

(Forward completed form to helpdesk@scccmh.org)

Date of Request: _____	**Supervisor's Signature: _____ (approves the following information)**
☐CMH ☐CMH Contractor	**Effective date: _____**
	Termination date: _____

☐Add ☐Update ☐Remove *(to be completed when staff terminate or transfer locations)*

☐Staff does not require a USER ID (Log-In) to access OASIS (Community Service Technicians)

Staff Name: _____ Tasks: _____

Job Title: _____

Provider Credentials (Clinical Staff Only) (i.e., LBSW, LMSW) : _____	**DOB: _____**

Phone Number of Staff: _____ E-Mail of Staff: _____

Agency Name: _____

Location(s) Name: _____

Please include applicable information as to licensing and credentials:

Degree: _____	**Effective Date: _____**	
NPI #: _____	**Effective Date: _____**	
License Name/Number: _____	**Effective Date: _____**	**Expiration Date: _____**
License Name/Number: _____	**Effective Date: _____**	**Expiration Date: _____**
Certification (s): _____ (i.e., FPE, CAD, PSS, etc.)	**Effective Date: _____**	**Expiration Date: _____**
Certification (s): _____ (i.e., BCBA, BT, CAADC, etc.)	**Effective Date: _____**	**Expiration Date: _____**
DEA# (Psychiatrist/Nurse Practitioner Only): _____	**Effective Date: _____**	**Expiration Date: _____**

☐Add to FAS System (applies to Children's Programs Only)

☐2-Factor Authentication Token Or ☐2-Factor Authentication Mobile App

~ BELOW FOR DATA MANAGEMENT TECHNICIAN USE ONLY ~

☐Data Management –E-Scribe Set Up

Date & Initials Rcv'd by DM Technician: _____

Date entered into OASIS system: _____

Date e-mail notice was sent to requestor: _____

OASIS Form: #08-0281
Reviewed Date: 11/1/2023
Policy Ref: #01-003-0005, #06-001-0110