CARES Team User(s) Activation Request Form

Person Requesting Activation

Name: _____ Title: _____

Agency: _____ E-Mail: _____

System Level User Information

CCNY Use Only:

Name	Email Address	Supervisor	Account Requested:	*Date Staff needs to be activated*	*Date Assigned*
			CARES		
			CARES		
			CARES		
			CARES		
			CARES		
			CARES		

Approval of Provider Change Request

The above request cannot be processed until this section is complete.

_____
(Signature)

_____
Name (Print)

_____
(Date)

_____
(Title)

Verification of Provider Change Request

I verify that the above-described provider(s) have been activated in Fidelity EHR according to the above instructions.

_____
CCNY(Signature)

_____
CCNY Name (Print)

_____
(Date)

.* This form can be sent to CCNY via email (dnichy@ccnyinc.org) or fax (716)855-0004 attn: Doug.