Service Capacity Management System (SCMS)
Account Request Form

Part A: Provider Information   Please provide the contact information of the person making

Provider Name:	
Name (Last, First):	
Title:	
Provider Address:	
Provider License ID#:	
Telephone Number:	**/ Fax Number:**
Email:	
Website:	

Part B: Account Requests   Please provide the contact info of the new user account (please print)

Last Name:	**Last Name:**
First Name	**First Name**
Title:	**Title:**
Telephone #:	**Telephone #:**
Email:	**Email:**
Site Location:	**Site Location:**
*Optional Link to Site License # / Location:	*Optional Link to Site License # / Location:

Print Name: **Signature:**   **Date:**

_____ _____ _____

By submitting this form you are authorizing the individual(s) listed for access to update your provider SCMS information
Please return completed forms to: imeinfo@ubhc.rutgers.edu or fax: 732 235-4898

Part C: IME Use Only

Username:	**Username:**
Password:	**Password:**
Notified Date:	**Notified Date:**
**Linked to:	****Linked to:**

Staff: _____ Date: _____ Update: _____