Kansas	**STATE BOARD OF PHARMACY** 800 SW Jackson, Suite 1414 Topeka, Kansas 66612-1244 www.pharmacy.ks.gov (785)296-4056	REGISTRATION APPLICATION: Durable Medical Equipment Form BA-16

All applications must be typed, be complete, and include all fees and supporting documentation before they will be processed by staff.

WHEN TO USE THIS FORM

Use this form if you do not have a pharmacy registration/permit and are providing only Durable Medical Equipment directly to consumers as defined by K.S.A. 65-1626(u).

FEES

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of $240.00. Fees are nonrefundable.

RESIDENT STATE AND EXPERIENCE

Attach a copy of your current registration or permit issued by the state of residence and the most recent inspection report conducted within the past two years by the state of residence.

OWNERSHIP

The Owner is considered the "applicant" for purposes of this form. If the Owner is a corporate or other legal entity, please complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate). If owned by other LLCs, partnerships, holding companies, etc., please submit information down to a person level of ownership.

Please indicate if this is a new application or a change:

☐ New Application Change (Check all that apply): ☐ Address ☐ Ownership ☐ Name

Previous registration number: _____ Effective date of change: _____

OWNER INFORMATION

Name		Other States Registered (abbrev.)	
Address			
City	State	Zip	County
Phone	Fax		Email

Ownership Type:

☐ Individual Provide SSN: _____ ☐ Government Entity Provide FEIN: _____

☐ Partnership ☐ LLC ☐ Corporation

Complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate)

BUSINESS INFORMATION

Trade/Business Name (printed on license)		Hours of Operation	
Physical Address (non-residential)			
City	State	Zip	County
Phone	Fax		Email

Initials: _____ OFFICE USE ONLY

Permit #: _____ Fee: $_____ Date: _____ Check #: _____

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AUTHORIZED AGENT INFORMATION (For partnerships, LLCs, nonprofits, and companies)

Name		Title	
Address			
City	State	Zip	County
Phone	Fax		Email

Designate where all formal correspondence, notices, and renewals should be sent:

☐ Owner ☐ Physical Location ☐ Authorized Agent

SERVICES PROVIDED

☐ Yes ☐ No Are oxygen and oxygen delivery systems being provided?

☐ Yes ☐ No If yes, does the applicant transfill or repackage oxygen?

If yes, attach a copy of the approved cylinder label and provide the FDA number:

_____

DISCIPLINARY INFORMATION

Applicant includes the legal ownership entity as well as each individual, owner, partner, corporate officer, or director.

☐ Yes ☐ No 1. Has the applicant ever been excluded from Medicare participation?

☐ Yes ☐ No 2. Has the applicant been convicted of any felony?

☐ Yes ☐ No 3. Has any license or registration, currently or previously held by the applicant been surrendered to, disciplined, revoked, or suspended by the federal or any state government?

If yes to any of the above questions, please attach Form S-300: Disciplinary History.

AUTHORIZED AGENT CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I understand any permit issued will be issued jointly to the applicant and myself, and I hereby accept responsibility as the authorized agent for such permit, which shall include compliance with the Kansas Pharmacy Act and Kansas Controlled Substances Act.

_____ _____

SIGNATURE DATE SIGNED

OWNER CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I have read and understand this application and that the information provided is true, correct, and complete to the best of my knowledge.

_____ _____

SIGNATURE DATE SIGNED