

**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.

**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/APPLICANT INFORMATION**

Name		Other States Registered (abbrev.)	
Address			
City	State	Zip	County
Phone	Fax		Email
Ownership Type: <input type="checkbox"/> Individual Provide SSN: _____ <input type="checkbox"/> Government Entity Provide FEIN: _____ <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> 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: _____	<b>OFFICE USE ONLY</b>
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** (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Apnea monitors  | <input type="checkbox"/> Low air loss cutaneous pressure management devices      |
| <input type="checkbox"/> Continuous positive airway pressure (CPAP)                        | <input type="checkbox"/> Nebulizers  |
| <input type="checkbox"/> Distribution of medical gasses to end users for human consumption | <input type="checkbox"/> Oxygen and oxygen delivery systems                      |
| <input type="checkbox"/> Electronic and computerized wheelchairs and seating systems       | <input type="checkbox"/> Respiratory disease management devices                  |
| <input type="checkbox"/> Feeding pumps   | <input type="checkbox"/> Sequential compression devices                          |
| <input type="checkbox"/> Home phototherapy devices   | <input type="checkbox"/> Transcutaneous electrical nerve stimulator (TENS) units |
| <input type="checkbox"/> Hospital beds   | <input type="checkbox"/> Ventilators   |
| <input type="checkbox"/> Infusion delivery devices   | <input type="checkbox"/> Other items containing a federal caution statement      |

Yes     No    **If oxygen services are selected above, 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.

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1. Has the applicant ever been excluded from Medicare participation?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2. Has the applicant been convicted of any felony?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>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?</b>

**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/APPLICANT 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