STATE BOARD OF PHARMACY
800 SW Jackson, Suite 1414
Topeka, Kansas 66612-1244
www.pharmacy.ks.gov (785)296-4056
pharmacy@ks.gov Fax (785) 296-8420

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 $300.00. Fees are nonrefundable.

REQUIREMENTS FOR NON-RESIDENT FACILITY

Attach a copy of your **current registration or permit** issued by the state of residence, the **most recent inspection report** conducted within the past two years by the state of residence or the National Association of Boards of Pharmacy, and the **S-350 Non-Resident Information form**.

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-This should be an individual preferably located at the facility.

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:

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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

Revised 06/19