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10451 Mill Run Circle, Suite 200
 Owings Mills, Maryland 21117

Application for BOC Accreditation

Facility Information		
Facility Name		Doing Business As (DBA)
Street Address		
City	State	Zip
Phone		Fax
Email		Website
CMS Provider #(PTAN)	National Provider Identifier #(NPI)	Employer Identification Number (EIN)
Practice Hours: <i>Indicate am/pm and if the facility closes for lunch.</i>		
Monday – Friday _____		Saturday _____ Sunday _____
Closed for lunch? Yes ___ No ___ If yes indicate time _____		
Please list Corporate officer/Owner(s) and Compliance Officer. <i>Print Name(s)</i>		
Corporate Officer(s)	Owner(s)	Compliance Officer
Certified/Licensed Personnel (as required by federal or state regulation)		
Practitioner	Credential Type	
Practitioner	Credential Type	
Practitioner	Credential Type	
Practitioner	Credential Type	

Owner/Corporate Officer Signature

In signing this affidavit, I attest, upon personal knowledge, that all information reported in this application, including any and all accompanying documentation, is complete, accurate and true, to the best of my knowledge. I understand that falsification of information may result in a denial or revocation of accreditation. I agree to notify BOC in writing of all changes to ownership, corporate structure, location and/or provision of services/equipment. In submitting this application, I understand that I am granting permission to BOC and its authorized representatives to inspect my facility during normal business hours and without prior notification.

Print Owner/Corporate Officer Name

Signature Owner/Corporate Officer

Facility Type (check all that apply) [Click here for full product list](#)

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Diabetic Footwear (custom) | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Orthotics (non-custom) | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Diabetic Footwear (non-custom) | <input type="checkbox"/> Ocular Prosthetics | <input type="checkbox"/> Pharmacy | |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Orthotics (custom) | <input type="checkbox"/> Prosthetics | |

Is your facility currently accredited? Yes No

If yes, by which accrediting organization? _____

Facility Accreditation Fees (fees are subject to change)

Initial Accreditation, Survey and First Year Fee	\$2499	2 nd Year Accreditation Fee	\$675
Additional on-site survey Fee (if required)	\$995	3 rd Year Accreditation Fee	\$675

Payment Method

Check# _____
 Visa MC Disc
 CC# _____

Payment Amount \$

Expiration Date (MM/YY)

CSC# (3 digit code)

Name as it appears on card

Cardholder Signature

The issuer of the card identified on this form is authorized to pay the amount shown as TOTAL upon proper presentation. I agree to pay such TOTAL (together with any other charges due thereon) subject to and in accordance with the Agreement governing the use of such card. Make Check or Money Order (in U.S. Dollars) payable to BOC. If your check is returned for any reason, you must submit a bank draft, money order or credit card payment with an additional fee of \$35.00 to cover the returned check processing fee. Applicants applying outside of the contiguous United States will be subject to an applicable surcharge for additional travel expenses. BOC does not offer refunds or accept post-dated checks.