



Addition of Product Categories Application

List product line additions

--

Facility Information

Facility Name		Doing Business As (DBA)		
Street Address				Suite Number
City		State	Zip Code	Country
Email		Fax Number		
Telephone Number		Mobile Number		
CMS Provider # (PTAN)	National Provider Identifier # (NPI)		Employer Identification # (EIN)	
National Association Board of Pharmacy # (NABP) <i>If applicable</i>		Drug Enforcement Agency # (DEA) <i>If applicable</i>		

Posted Business Hours: Indicate AM/PM and if the facility closes for lunch.

	Closed	Open Time	Close Time	Closed for Lunch	Lunch Start Time	Lunch End Time
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

Have there been changes to your Certified/Licensed Personnel?	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

If you answered yes to the above question please indicate these changes below and submit supporting documentation:



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, 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

Date

Product Line Change Fee

On-Site Survey Fee (if needed)

\$1,455

For the following product categories there is only a \$150 administrative fee. *(No survey required)*

- Blood Glucose Monitors and Supplies- Mail Order (DM06)
- Blood Glucose Monitors and Supplies- Non Mail Order (DM05)
- Canes and Crutches (M01)
- Commodes/Urinals/Bedpans (DM02)
- Enteral Nutrients (PE03)

- Enteral Nutrients Equipment and Supplies (PE04)
- Ostomy Supplies (PD06)
- Support Surfaces: pressure reducing beds/mattresses/overlays/pads (DM20)
- Surgical Dressings (S01)
- Urological Supplies (PD09)
- Walkers (M05)
- Wheelchair Seating/Cushions (M10)

Payment Method

Credit Card Payment

Visa Mastercard Discover American Express

Check Payment

Check (enclosed)

Check Number

Credit Card Number

Security Code

Expiration Date

Billing Address

City

State

Zip 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 Payment Amount upon proper presentation. I agree to pay such Payment Amount (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 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.

You may email or fax this application and documentation to:

fa@bocusa.org
410.581.6228

Or, mail completed application and documentation to:

Board of Certification/Accreditation
Attention: Accreditation Department
10461 Mill Run Circle, Suite 1250
Owings Mills, Maryland 21117