



Accreditation Application

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	<input type="checkbox"/>			<input type="checkbox"/>		
Tuesday	<input type="checkbox"/>			<input type="checkbox"/>		
Wednesday	<input type="checkbox"/>			<input type="checkbox"/>		
Thursday	<input type="checkbox"/>			<input type="checkbox"/>		
Friday	<input type="checkbox"/>			<input type="checkbox"/>		
Saturday	<input type="checkbox"/>			<input type="checkbox"/>		
Sunday	<input type="checkbox"/>			<input type="checkbox"/>		

How did you hear about BOC?

<input type="checkbox"/> BOC Website	<input type="checkbox"/> CMS	<input type="checkbox"/> Social Media
<input type="checkbox"/> Colleague	<input type="checkbox"/> Internet	<input type="checkbox"/> Tradeshow
Did you use a consultant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?
	<input type="checkbox"/> <input type="checkbox"/>	

Please list Corporate Officer/Owner(s) and Compliance Officer | Print name.

Corporate Officer(s)	Owner(s)	Compliance Officer



Credentialed Personnel | Please include additional practitioners/pharmacists/pharmacy technicians on an attached document.

Practitioner/Pharmacist	Credential Type
Practitioner/Pharmacist Technician	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, 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
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Facility Type | Check all that apply. [Click here for full product list.](#)

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"/>	[Patterned Area]
Durable Medical Equipment <input type="checkbox"/>	Orthotics (custom) <input type="checkbox"/>	Prosthetics <input type="checkbox"/>	
Is your facility currently accredited?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, by which accrediting organization?	

Facility Accreditation Fees | Fees are subject to change.

	DMEPOS	Pharmacy	DMEPOS + Pharmacy
Initial Site Survey and 3-Year Accreditation Fees (all inclusive)	\$4,499 <input type="checkbox"/>	\$2,599 <input type="checkbox"/>	\$4,999 <input type="checkbox"/>
Additional On-Site Survey Fee (if required)			\$1,455
Optional Expedited On-Site Survey Fee (please call for details)			\$ 700

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