



## Reassignment 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
<b>Monday</b>	<input type="checkbox"/>			<input type="checkbox"/>		
<b>Tuesday</b>	<input type="checkbox"/>			<input type="checkbox"/>		
<b>Wednesday</b>	<input type="checkbox"/>			<input type="checkbox"/>		
<b>Thursday</b>	<input type="checkbox"/>			<input type="checkbox"/>		
<b>Friday</b>	<input type="checkbox"/>			<input type="checkbox"/>		
<b>Saturday</b>	<input type="checkbox"/>			<input type="checkbox"/>		
<b>Sunday</b>	<input type="checkbox"/>			<input type="checkbox"/>		

**How did you hear about BOC?**

<input type="checkbox"/> BOC Website		<input type="checkbox"/> Print Advertisement		<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 on an attached document.**

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, 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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**Please complete a product category list and attach to this application. [Click here for full product list.](#)**

**Facility Transfer Accreditation Fees | Fees are subject to change.**

The supplier is required to provide:

- verification of active and good standing status with current AO
- copy of most recent site visit report
- copy of current accreditation certificate
- listing of product categories included on existing accreditation
- copies of current business/professional licenses and certifications
- copy of most current Performance Improvement (PI) report/log
- 5 current patient files/demographics including the DME item(s) supplied and the corresponding prescription

A survey fee of \$1,399.00 may apply **if** you are unable to furnish a copy of your original survey from your current accrediting organization or if you cannot provide any of the information listed above. Applicants applying outside of the contiguous United States will be subject to an applicable surcharge for additional travel expenses.

**You may email or fax this application and documentation to:**

[fa@bocusa.org](mailto: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

**Payment Method – IF Survey Fee (\$1,455) is Required**

<b>Credit Card Payment</b> <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express		<b>Check Payment</b> <input type="checkbox"/> 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.