



10461 Mill Run Circle, Suite 1250 • Owings Mills, MD 21117
 phone 877.776.2200 • local 410.581.6222 • fax 410.581.6228 • online www.bocusa.org

Reaccreditation 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: <i>Indicate AM/PM and if the facility closes for lunch.</i>						
	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"/>		

Have the Corporate office/owner or compliance officer names changed?	Yes	No
Have there been changes to your Certified/Licensed Personnel?	Yes	No
Has there been a change to your product line?	Yes	No

*If you answered **yes** to any of the above questions regarding changes in your practice 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

Facility Accreditation Fees | Fees are subject to change.

DMEPOS Accreditation, Site Survey, and 3-Year Accreditation Fees (all inclusive)	\$4,299
Pharmacy Only Accreditation, Site Survey, and 3-Year Accreditation Fees (all inclusive)	\$2,599
Additional On-Site Survey Fee (if required)	\$1,399
Optional Expedited On-Site Survey Fee (please call for details)	\$ 600

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

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