



O&P Accreditation Application



O&P Special Pricing \$2,599
 (includes all services)
**Plus, make the switch to
 BOC for FREE!**

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?
Were you referred by a BOC-accredited facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, facility name:
		If yes, facility representative:

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

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

Diabetic Footwear (custom) <input type="checkbox"/>	Mastectomy <input type="checkbox"/>	Orthotics (custom) <input type="checkbox"/>
Diabetic Footwear (non-custom) <input type="checkbox"/>	Prosthetics <input type="checkbox"/>	Orthotics (non-custom) <input type="checkbox"/>
Ocular 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.

Initial Site Survey, and 3-Year O&P Accreditation Fees (all inclusive)	\$2,599	<input type="checkbox"/>
Additional On-Site Survey Fee (if required)	\$1,399	<input type="checkbox"/>
Expedited Survey Fee	\$ 600	<input type="checkbox"/>

Payment Method

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