Board of Certification/Accreditation

877.776.2200 phone
410.581.6228 fax
bocusa.org

Lymphedema/Compression Accreditation Application

Facility Information

Facility Name*		Doing Business As (DBA)	
Street Address*		Suite Number	
City*	State*	Zip Code*	Country*
Business Email*		Secondary Email	
Facility Phone Number*	Mobile Number*	Fax Number	
CMS Provider # (PTAN)	National Provider Identifier # (NPI)	Employer Identification # (EIN)	
Is your facility currently accredited?* ☐ Yes ☐ No		If yes, by which accrediting organization?	

Posted Business Hours (For every day, please indicate AM/PM and if the facility closes for lunch)

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

Credentialed Personnel (Please include additional practitioners on an attached document)

Name and Certification (CLT, PT, OT, CMF, etc.)	Certificate #
Name and Certification (CLT, PT, OT, CMF, etc.)	Certificate #

Officers (Please print full names)

Owners*	Compliance Officers*	Corporate Officers(s)

How did you hear about BOC?

☐ BOC Website ☐ CMS ☐ Internet ☐ Social Media ☐ Colleague ☐ Tradeshow:

Did you use a consultant?* ☐ Yes ☐ No	Third Party Counsultant Name	Third Party Counsultant Email

Did you work with a BOC representative?* ☐ Yes ☐ No ☐ Cynthia Tolson ☐ Daniel Holsey ☐ Josh Bressler

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)

Lymphedema/Compression Site Survey and 3-Year Accreditation Fees:	**$2,599**
Optional Expedited Survey Fee (10 Business Days):	**$ 700**
TOTAL FEE:	**$**

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. Applications from outside of the contiguous United States will be subject to a surcharge for additional travel expenses. BOC does not offer refunds or accept post-dated checks.

An additional Site Survey fee of $1455.00 may be compulsory under specific circumstances. Under these circumstances the facilities will be made aware of this prior to the survey taking place.

Notwithstanding anything to the contrary contained herein, to the maximum extent permitted by applicable law, except in the instance of willful misconduct or gross negligence of BOC (or any of its employees, agents, or contractors ("Related Parties")), the maximum aggregate liability of BOC arising out of or in connection with this Accreditation Application (including any inspection or audit of Applicant's facility) shall not exceed the aggregate amount paid or payable by Applicant to BOC for the Application fee and all services, including any inspection or audit, giving rise to such liability, as of the date of the events or circumstances giving rise to such liability.

Submit this application and any additional documentation by **email, fax, or mail.**

EMAIL	FAX	MAIL
fa@bocusa.org	**410.581.6228**	**Board of Certification/Accreditation** Attention: Accreditation Department 10461 Mill Run Circle, Suite 1250 Owings Mills, Maryland 21117