STATE BOARD OF PHARMACY
800 SW Jackson, Suite 1414
Topeka, Kansas 66612-1244
www.pharmacy.ks.gov (785)296-4056
pharmacy@ks.gov Fax (785) 296-8420

REGISTRATION APPLICATION: Ambulance/EMS
Form BA-09

All applications must be typed, be complete, and include all fees and supporting documentation before they will be processed by staff.

FEES

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of $20.00. Fees are nonrefundable.

AMBULANCE LICENSE AND NUMBER OF PERMITS NEEDED

Attach a copy of your current ambulance license from the Kansas Board of Emergency Medical Services.
The Board requires an Ambulance permit for each DEA Registration permit and at least one for each central drug repository.

OWNERSHIP

The Owner is considered the “applicant” for purposes of this form. If the Owner is a corporate or other legal entity, please complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate).

Please indicate if this is a new application or a change:

☐ New Application   Change (Check all that apply): ☐ Address   ☐ Ownership   ☐ Name
Previous registration number: ______________________ Effective date of change: __________________

OWNER INFORMATION

Name		Other States Registered (abbrev.)	
Address			
City	State	Zip	County
Phone	Fax		Email*

Ownership Type:

☐ Individual Provide SSN: __________________   ☐ Government Entity Provide FEIN: __________________

☐ Partnership ☐ LLC ☐ Corporation
Complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate)

*In accordance with K.S.A. 77-531(a)(3), Applicant consents to service via electronic mail. Service by electronic mail is complete upon transmission.

AMBULANCE INFORMATION

Name		Kansas EMS License Number	
Physical Address			
City	State	Zip	County
Phone	Fax		Email

DESIGNATED REPRESENTATIVE INFORMATION-This should be an individual preferably located at the facility.

Name		Title	
Address			
City	State	Zip	County
Phone	Fax		Email

Designate where all formal correspondence, notices, and renewals should be sent:

☐ Owner   ☐ Physical Location   ☐ Designated Representative

OFFICE USE ONLY

Initials: _________

Permit #:_______________ Fee: $_________ Date:__________ Check #: _______________

Revised 03/2026

DRUG SCHEDULES (Check all that apply)

- ☐ Schedule II narcotic
- ☐ Schedule II non-narcotic
- ☐ Schedule III narcotic
- ☐ Schedule III non-narcotic
- ☐ Schedule IV
- ☐ Schedule V

If you selected any Drug Schedules above, please provide either:

☐ A copy of the current DEA Registration
Current DEA Registration Number ______________________ Expiration Date ______________________

☐ The submission date for the pending DEA Registration Application ______________________

DISCIPLINARY INFORMATION

Applicant includes the legal ownership entity as well as each individual, owner, partner, corporate officer, or director.

☐ Yes ☐ No **1.** Has the applicant been convicted of any violation of state or federal law related to any controlled substance?

☐ Yes ☐ No **2.** If so, was the conviction a felony?

☐ Yes ☐ No **3.** Has the applicant had any license or registration surrendered, denied, suspended, or revoked under the Kansas Uniform Controlled Substances Act?

If yes to any of the above questions, please attach Form S-300: Disciplinary History.

DESIGNATED REPRESENTATIVE CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I understand any permit issued will be issued jointly to the applicant and myself, and I hereby accept responsibility as the designated representative for such permit, which shall include compliance with the Kansas Pharmacy Act and Kansas Controlled Substances Act.

____ ______________________
SIGNATURE DATE SIGNED

OWNER CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I have read and understand this application and that the information provided is true, correct, and complete to the best of my knowledge.

____ ______________________
SIGNATURE DATE SIGNED