

**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:  
 Durable Medical Equipment  
 Form BA-16**

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

**WHEN TO USE THIS FORM**

Use this form if you do not have a pharmacy registration/permit and are providing only Durable Medical Equipment directly to consumers as defined by K.S.A. 65-1626(x).

**FEES**

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of \$300.00. Fees are nonrefundable.

**APPLICATION REQUIREMENTS**

The following documents are required for the application to be complete:

- Copy of current registration or permit issued by state of residence
- Facility inspection report conducted within the past two years by state of residence or National Association of Boards of Pharmacy (applies to non-resident facilities only; pre-opening inspection conducted by Kansas compliance inspector required for in-state applicants)
- List of other states in which registered, with permit numbers
- S-300 Disciplinary History form and explanation documents if any Discipline Information questions on page 2 of application are answered "yes".
- S-310, S-320 or S-330 ownership forms and/or business organization chart, along with supporting ownership documents (refer to top of individual forms for requirement). See Ownership information below for further detail
- S-350 Non-Resident Information form (non-resident facilities only)

**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). If owned by other LLCs, partnerships, holding companies, etc., please submit information down to a person level of ownership. Refer to K.A.R. 68-14-4.

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			
Address			
City	State	Zip	County
Phone	Fax		Email*
Ownership Type: <input type="checkbox"/> Individual Provide SSN: _____ <input type="checkbox"/> Government Entity Provide FEIN: _____ <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> 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.

Initials: \_\_\_\_\_

**OFFICE USE ONLY**

Permit #: \_\_\_\_\_ Fee: \$ \_\_\_\_\_ Date: \_\_\_\_\_ Check #: \_\_\_\_\_



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**BUSINESS INFORMATION**

Trade/Business Name (printed on license)		Hours of Operation	
Physical Address (non-residential)			
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

**SERVICES PROVIDED**

- Yes     No    **Are oxygen and oxygen delivery systems being provided?**  
 Yes     No    If yes, does the applicant transfill or repackage oxygen?  
If yes, attach a copy of the approved cylinder label and provide the FDA number:

**DISCIPLINARY INFORMATION**

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

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1. Has the applicant ever been excluded from Medicare participation?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2. Has the applicant been convicted of any felony?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>3. Has any license or registration, currently or previously held by the applicant been surrendered to, disciplined, revoked, or suspended by the federal or any state government?</b>
<b>If yes to any of the above questions, please attach Form S-300: Disciplinary History.</b>	

**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