

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
 Madison, WI 53708-8935
Fax #: (608) 251-3036
Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way
 Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

PHARMACY EXAMINING BOARD

HOME MEDICAL OXYGEN PROVIDER ACCREDITING ORGANIZATIONS

In order to obtain a Home Medical Oxygen Provider license, accreditation is required by one of the following organizations:

Accrediting Organization (AO)	Contact Information
Accreditation Commission for Health Care, Inc. (ACHC)	139 Weston Oaks Court Cary, NC 27513 (855) 937-2242 http://www.achc.org
American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC)	330 John Carlyle Street, Suite 210 Alexandria, VA 22314 (703) 836-7114 http://www.abcop.org
Board of Certification/Accreditation (BOC)	10451 Mill Run Circle, Suite 1250 Owings Mills, MD 21117 (877) 776-2200 http://www.bocusa.org
Commission on Accreditation of Rehabilitation Facilities (CARF)	6951 E. Southpoint Road Tucson, AZ 85756 (888) 281-6531 http://www.carf.org/dmepos
Community Health Accreditation Program, Inc. (CHAP, Inc.)	1275 K Street, NW, Suite 800 Washington, DC 20005 (202) 862-3413 http://www.chapinc.org
Healthcare Quality Association on Accreditation (HQAA)	114 East 4th Street, Suite 200 Waterloo, IA 50703 (866) 909-4722 http://www.hqaa.org
National Association of Boards of Pharmacy (NABP)	1600 Feehanville Drive Mount Prospect, IL 60056 (847) 391-4406 http://www.nabp.net
The Compliance Team, Inc.	P.O. Box 160 905 Sheble Lane, Suite 102 Spring House, PA 19477 (215) 654-9110 http://www.thecomplianceteam.org
The Joint Commission	One Renaissance Boulevard Oakbrook Terrace, IL 60181 (630) 792-5800 http://www.jointcommission.org

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HOME MEDICAL OXYGEN PROVIDER APPLICATION

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK		<input type="checkbox"/> Your name, address, telephone number, and email address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).
Current WI License Number:	You must choose one of the following types:	
<input type="text"/> _48	<input type="checkbox"/> New Provider <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Change of Location	
Facility Name (individual, partnership, association or corporation)		
<input style="width:100%;" type="text"/>		
Doing Business As (DBA) Name (Name or title under which business is operated. This must be the name on the provider label.) (Note: This is the name that will appear on the license once issued.)		
<input style="width:100%;" type="text"/>		
Daytime Telephone Number	Fax Number	
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	
FEIN Number	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.	
<input type="text"/> - <input type="text"/>		
Facility Address (number, street, city, state, zip)		
<input style="width:100%;" type="text"/>		
Mailing Address until Day of Opening (if applicable) (number, street, city, state, zip)		
<input style="width:100%;" type="text"/>		
Email Address		
<input style="width:100%;" type="text"/>		
NAME OF OWNER OR NAMES AND TITLES OF ALL PARTNERS, CORPORATE OFFICERS AND SHAREHOLDERS OWNING ABOVE 20% OF VOTING STOCK (Attach additional sheets in the same format if necessary.)		
Name	Address (City, State, Zip Code)	Registered Pharmacist?
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Address (City, State, Zip Code)	Registered Pharmacist?
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICATION FEE: Please make check payable to DSPTS and attach to application.

\$59.00 Initial Credential Fee

For Receipting Use Only (48)

Wisconsin Department of Safety and Professional Services

Please answer the following questions. (Attach additional sheets if necessary.)

YES NO

1. Have the principals or applicant ever been charged with a felony or misdemeanor?
If yes, please complete Form #2252 and provide details about the conviction, including date of conviction penalty, and a copy of the court documents. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)

2. Have any of the principals or applicant conducted a similar business in any other state?
If yes, please indicate license number/state issued below.

3. Has the applicant ever made application for a license to operate a Pharmacy, Drug/Device Manufacturer or Wholesale Distributor of Prescription Drugs? **If yes, was the application denied (and for what reason)?**

4. Applicant proposes to sell medical oxygen to (Check all that apply.):
 Nursing Homes Home Health Agencies Public Hospitals
 Ambulance Services Other: _____

5. Please list the applicant's Accrediting Organization (AO):

CONTINUING DUTY OF DISCLOSURE:

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT:

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Continuing Duty of Disclosure and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature of Applicant

Title

Printed Name

□□ / □□ / □□

Date