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

☐ Your name, address, phone number, and e-mail address are available to the public. Check box to withhold street address/po box, phone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Current WI License Number: _____ **-48**

You must choose one of the following types:

☐ New Provider ☐ Change of Ownership ☐ Change of Location

Facility Name (individual, partnership, association or corporation)

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.)

Daytime Telephone Number ___ - ___ - ____

Fax Number ___ - ___ - ____

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.

Facility Address (number, street) (city) (state) (zip code)

Mailing Address until Day of Opening (if applicable) (number,street) (city) (state) (zip code)

E-mail Address

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?
		☐ Yes ☐ No
		☐ Yes ☐ No

APPLICATION FEE: Please make check payable to DSPS and attach to application. To pay by credit card see Form #3071.

$59.00 Initial Credential Fee

For Receipting Use Only (48)

Committed to Equal Opportunity in Employment and Licensing

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 convicted of a misdemeanor, felony, or other violation of federal or state law or do the principals or applicant have any felony, misdemeanor, or other violation of federal or state law charges pending against the principals or applicant in this state or any other? This includes convictions resulting from a plea of no contest, a guilty plea, or verdict. **If yes, submit Convictions and Pending Charges Form #2252 and required documentation.**	☐	☐
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 **(Print and Sign Form)**

Title

Printed Name

Date