



Certified Durable Medical Equipment (CDME) Application *indicates a required field

Personal Information

First Name*	Last Name*	Middle Initial	Gender M F
Street Address*		Apartment Number	
City*	State*	Zip Code*	Country*
Email*		Preferred Mailing Address Home Work	
Mobile Number*	Phone Number*		
Date of Birth (mm/dd/yyyy)*	Social Security Number		

Professional Information

Current Professional Credentials (examples: BOCO, BOCP, CMF, etc.)			
Company Name			
Business Address		Suite Number	
City	State	Zip Code	Country
Phone Number	Fax Number	Is this a BOC-accredited facility? Yes No	

Experience Requirements*

I have a minimum of 500 hours (approximately 12 weeks of full-time work) of documented experience. Yes No

BOC performs random audits, and evidence of documented patient care must be available. Retain patient care logs and/or a notarized letter of attestation from the certified practitioner or supervisor under whom you worked readily available. Failure to document patient care hours may result in revocation of certification.

Questionnaire

- | | | |
|--|-----|----|
| Have you been named as a defendant in a professional liability suit during the past five years? | Yes | No |
| Any professional practice judgments or settlements against you in the past five years? | Yes | No |
| Has your professional certification/license ever been affected negatively by any agency? | Yes | No |
| Have you ever been convicted of one or more felonies? | Yes | No |
| Has Medicaid or any other medical plan ever brought charges against you for any reason? | Yes | No |
| Has your professional liability coverage ever been restricted, limited, denied, or denied renewal? | Yes | No |

If you answered "Yes" to any of the above, please enclose an explanation on a separate sheet.



How did you hear about BOC?

Colleague BOC Website Webinar Social Media Tradeshow:

Attestation

I attest that the information reported on this application, and in all accompanying documentation, is true and accurate to the best of my knowledge.

Applicant Signature

Exam Information

BOC's testing provider, PSI Services, will contact you regarding your exam appointment by mail and email.

Certification Fees (Fees are subject to change)

Application Fee (required)* **\$50**

Multiple Choice Exam: **\$100**

TOTAL FEE: \$

Take your computer-based, multiple-choice exam at a testing center or online from your home or office. Receive your results instantly.

Payment Method

Credit Card Payment

Visa MasterCard Discover American Express

Credit Card Number

Check Payment

Check Enclosed Check 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. BOC does not offer refunds or accept post-dated checks.

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

EMAIL

cert@bocusa.org

FAX

410.581.6228

MAIL

Board of Certification/Accreditation
Attention: Certification Department
10461 Mill Run Circle, Suite 1250
Owings Mills, Maryland 21117