For Office Use Only: Date Received: _____

$500.00 _____

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150

REGISTRATION TO OPERATE A PHYSICIAN OWNED PAIN MANAGEMENT FACILITY

SECTION I:

☐ Initial Application for Licensure **($500 Fee, Payable to Kentucky Board of Medical Licensure)**
☐ Change of location **(No Fee)** – effective date: _____
☐ Change in clinic name only **(No fee)** – effective date: _____
☐ New permanent or interim medical director **(No fee) - Please complete Section II and Section V.**

Important: All questions must be answered or this application will be returned for completion. If the question does not apply, please indicate n/a.

1. Corporate or Legal Name of Pain Management Facility: _____

2. Doing Business As Name: _____

3. Federal Tax Identification Number (FEI#): _____

4. List the **primary** facility address and any **additional** clinic locations below:

Primary Facility Address: _____
(Street)

_____
(City) (State) (Zip Code)

(Please attach a separate sheet if necessary for additional locations)

Additional Locations: _____
(Street)

_____
(City) (State) (Zip Code)

5. Pain Management Facility Telephone Number: ( ) _____

6. Pain Management Facility Fax Number: ( ) _____

7. Pain Management Facility Email Address: _____

Pain Management Web Site: _____

8. Provide Business Operating Hours:

Monday	____ : ____ am/pm to ____ : ____ am/pm
Tuesday	____ : ____ am/pm to ____ : ____ am/pm
Wednesday	____ : ____ am/pm to ____ : ____ am/pm
Thursday	____ : ____ am/pm to ____ : ____ am/pm
Friday	____ : ____ am/pm to ____ : ____ am/pm
Saturday	____ : ____ am/pm to ____ : ____ am/pm
Sunday	____ : ____ am/pm to ____ : ____ am/pm

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9. Provide hours Medical Director Present in Clinic. Pursuant to 201 KAR 9:250 Section 4(1)(e), a qualified physician owner or owner's designee shall be physically present and practicing medicine or osteopathy in each practice location for at least fifty percent (50%) of the time patients are present at the practice location(s) of the facility or the facility shall notify the Board of the fact in writing and include reason for non-compliance.

Monday	____ : ____ am/pm to ____ : ____ am/pm
Tuesday	____ : ____ am/pm to ____ : ____ am/pm
Wednesday	____ : ____ am/pm to ____ : ____ am/pm
Thursday	____ : ____ am/pm to ____ : ____ am/pm
Friday	____ : ____ am/pm to ____ : ____ am/pm
Saturday	____ : ____ am/pm to ____ : ____ am/pm
Sunday	____ : ____ am/pm to ____ : ____ am/pm

10. Names and addresses of any and all pain management facility owner(s), principal(s), officer(s), agent(s), administrator and clerical staff– use additional sheets of paper if necessary.

Owner(s):

Name _____ License Number: _____

Address _____
(Street)

_____
(City (State) (Zip)

Telephone Number _____

Pursuant to 201 KAR 9:250 Section 4(1)(g), the owner or owner's physician designee must meet one of the qualifications below. Please check which qualification applies:

☐ Hold a current subspecialty certification in pain management by a member board of the American Board of Medical Specialties

☐ Hold a current certificate of added qualification in pain management by the American Osteopathic Association Bureau of Osteopathic Specialties

☐ Hold a current subspecialty certification in hospice and palliative medicine by a member board of the American Board of Medical Specialties

☐ Hold a current certificate of added qualification in hospice and palliative medicine by the American Osteopathic Association Bureau of Osteopathic Specialties.

☐ Hold a current board certification by the American Board of Pain Medicine

☐ Hold a current board certification by the American Board of Interventional Pain Physicians

☐ Completed an accredited residency or fellowship in Pain Management that included a rotation of at least five months in pain management.

☐ Was an owner of the specific pain management facility prior to and continuing through July 20, 2012 and meets qualifications in 201 KAR 9:250 Section 4(1)(g)(2).

Principal(s):

Name _____ License Number, if applicable: _____

Address_____

City, State, Zip_____

Telephone Number: _____

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(Continuation of Question 10)

Officer(s):

Name _____ License Number, if applicable: _____

Address_____

City, State, Zip_____

Telephone Number _____

Agent(s):

Name _____ License Number, if applicable: _____

Address_____

City, State, Zip_____

Telephone Number _____

Administrator if not the Same Person as the Medical Director:

Name _____ License Number, if applicable: _____

Address_____

City, State, Zip_____

Telephone Number _____

Clerical Staff:

Name _____ License Number, if applicable: _____

Address_____

City, State, Zip_____

Telephone Number _____

Clerical Staff:

Name _____ License Number, if applicable: _____

Address_____

City, State, Zip_____

Telephone Number _____

Clerical Staff:

Name _____ License Number, if applicable: _____

Address_____

City, State, Zip_____

Telephone Number _____

SECTION II: MEDICAL DIRECTOR INFORMATION

11. Physician Name: _____

Date Physician Designated as Facility's Medical Director: _____

Kentucky License Number: _____ DEA Number: _____

Address: _____
(Street)

_____
(City) (State)
(Zip)

Email address: _____

Telephone Number (Work): _____

American Board of Medical Specialty: _____

SECTION III: PHYSICIANS AND PRESCRIBING PRACTITIONERS

12. In addition to the medical director, list the names and addresses of all physicians and Advanced Practice Registered Nurses (APRN) under contract or employed by the facility – use additional sheets of paper if necessary. Pursuant to 201 KAR 9:250 Section 5(2), each licensed physician who will prescribe or dispense controlled substances shall successfully complete a minimum of ten (10) hours of Category I continuing medical education in pain management during each registration period throughout the employment agreement with the facility.

a Physician/APRN Name: _____

b Kentucky License Number: _____ DEA Number: _____

c. Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

d. Telephone Number: _____

e. Email Address: _____

f. American Board of Medical Specialty : _____

****

a. Physician/APRN Name: _____

b. Kentucky License Number: _____ DEA Number: _____

c Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

d. Telephone Number: _____

e. Email Address: _____

f. American Board of Medical Specialty: _____

(Continuation of Section III: PHYSICIANS AND PRESCRIBING PRACTITIONERS)

a. Physician/APRN Name: _____

b. Kentucky License Number: _____ DEA Number: _____

c. Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

d. Telephone Number: _____

e. Email Address: _____

f. American Board of Medical Specialty: _____

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SECTION IV: OFFICE INFORMATION

a. Has any person with ownership interest in this pain management facility had any previous ownership interest in a health care facility which had its license revoked or voluntarily relinquished its license as the result of an investigation or pending disciplinary action? If yes, please describe the circumstances on a separate sheet of paper. Yes ☐ No ☐

b. Has this facility ever had an administrative sanction or criminal conviction relating to controlled substances imposed on the facility or any person employed by the facility? If yes, please describe the circumstances on a separate sheet of paper. Yes ☐ No ☐

c. Has the applicant or any physician or prescribing practitioner with a contractual or or employment relationship to the applicant had his/her DEA number revoked? If yes, please describe the circumstances on a separate sheet of paper. Yes ☐ No ☐

d. Has the applicant or any physician or prescribing practitioner with a contractual or employment relationship to the applicant had his/her license to prescribe, dispense, or administer a controlled substance denied by any jurisdiction? If yes, please describe the circumstances on a separate sheet of paper. Yes ☐ No ☐

e. Has the applicant or any physician or prescribing practitioner with a contractual or employment relationship to the applicant had any disciplinary limitation placed on his or her license by the Kentucky Board of Medical Licensure, Kentucky Board of Nursing, or a licensing board of another state and the disciplinary action was the result of illegal or improper prescribing or dispensing of controlled substances? If yes, please describe the circumstances on a separate sheet of paper. Yes ☐ No ☐

f. Has the applicant or any physician with a contractual or employment relationship to the applicant been convicted of or plead guilty or nolo contendere to, regardless of adjucation, an offense that constitutes a felony for receipt of illicit and diverted drugs, including a controlled substance listed as Schedule I, Schedule II, Schedule III, Schedule IV, or Schedule V in this state or the United States? If yes, please describe the circumstances on a separate sheet of paper. Yes ☐ No ☐

g. Does the pain management facility accept private health insurance as one of the facility's allowable forms of payment for goods or services provided, and does the facility accept payment for services rendered or goods provided to a patient only from the patient or patient's insurer, guarantor, spouse, parent, guardian, or legal custodian? Yes ☐ No ☐

Private health insurance plans accepted: _____

SECTION V: FACILITY'S STATEMENT

Are the majority of patients of the practitioners at the facility provided treatment for Pain that includes the use of controlled substances? Yes ☐ No ☐

SECTION VI: APPLICANT'S STATEMENT

I hereby state that the facility meets all requirements of KRS 218A.175 and 201 KAR 9:250. I agree to notify the Kentucky Board of Medical Licensure in writing within 10 days of any changes to the information reported on this application.

I certify that the information provided in this application is accurate and correct, and I acknowledge that falsification of this application shall result in the denial or revocation of licensure.

Type or print name of authorized representative and position/title: _____

Signature of authorized representative: _____

Date: _____

SECTION VII: MAILING INSTRUCTIONS

The original application with the applicant's original signature must be mailed to the Kentucky Board of Medical Licensure (faxed copies are not acceptable).

Mail this application and the fee ($500.00) to:

Kentucky Board of Medical Licensure
310 Whittington Pkwy, #1B
Louisville, KY 40222

The initial licensure or annual re-licensure fee shall be:

- **Payable to the Kentucky Board of Medical Licensure**
- **Submitted with this application; and**
- **Paid by check, money order or credit card. If paying by credit card, please complete the information below and return with this application.**

Credit Card Information:

*****Please circle type of card: Visa, Mastercard, Discover, American Express**

Credit Card #
☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Exp. Date:
(MM-YY) ☐☐ - ☐☐

Security Code on Back of Card: ☐☐☐

Credit Card Holder Name:_____

Billing Address Street: _____

Billing City, State, Zip: _____

All credit information will be purged after the payment is processed.