Print Form

REINSTATEMENT OF REGISTRATION TO DISPENSE CONTACT LENSES BY MAIL

Completion of this application form is necessary for consideration for registration. Disclosure of this information is voluntary; however, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for registration have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application may be subject to the public information laws of this state.

Please type or print. When space provided is insufficient, attach additional pages.

Registration to dispense contant lenses by mail expires one year following the date issued. The person to whom registration is issued is responsible for seeking renewal each year.

1. Business Name:

_____

Other names used, including trade names: _____

2. Address:

Mailing Address: _____
public information street city county state zip

E-mail: _____

Website: _____

Dispensing Facility: _____
street city county state zip

3. Phone number (include area codes)**:**

Voice: _____ Fax: _____ Toll Free for Consumers: _____

4. Type of Business (check one):

- ☐ General Corporation
- ☐ Professional Corporation
- ☐ Limited Liability Company
- ☐ Other: _____
- ☐ Limited Partnership
- ☐ Partnership

5. Corporate Officers: ☐ not applicable

President's Name: _____
first middle last

Residential Address: _____
street city county state zip

Secretary's Name: _____
first middle last

Residential Address: _____
street city county state zip

Treasurer's Name: _____
first middle last

Residential Address: _____
street city county state zip

6. Agent Designated for Service of Legal Process:

Name: _____

Residential Address: _____
street city county state zip

7. Name, title and street address of each individual responsible for overseeing the dispensing of contact lenses to persons located in Kansas (attach list if more than one)**.**

Name: _____
first middle last title

Address: _____
street city state zip country

Voice: _____ Fax: _____ E-mail: _____

8. Does the state in which the dispensing facility is located require a license/registration to dispense contact lenses?

☐ No ☐ Yes If yes please provide:

State/Country/Jurisdiction	License, Registrant, Certificate no.	Status	Issue Date
_____	_____	_____	_____

9. Regular Hours of Operation:

MON _____ TUE _____ WED _____

THU _____ FRI _____ SAT _____

SUN _____

10. Applicant acknowedges and certifies as follows:

a) Applicant is required to comply with directions and request for information from the appropriate regulatory agency of each state in which applicant is licensed or registered;
b) Applicant is required to respond directly and within a reasonable period of time, not to exceed 15 days, to all communications from the Kansas State Board of Healing Arts concerning the dispensing of contact lenses;
c) Applicant is required to maintain records of contact lenses that are dispensed in Kansas, and their corresponding valid, unexpired prescriptions;
d) Applicant is required and agrees to cooperate with the Kansas State Board of Healing Arts in providing information to the regulatory agency of any state in which the Applicant is licensed or registered concerning matters related to the dispensing of contact lenses in Kansas;
e) Applicant is required to provide a toll-free telephone service for responding to questions and complaints from individuals in Kansas during Applicant's regular hours of operation, and agrees to include the toll-free number in literature provided with mailed contact lenses;
f) Applicant is required and agrees to refer all questions relating to eye care for the lenses prescribed to the licensee who determined the contact lens prescription;

g) Applicant is required and agrees to provide the following written notification whenever contact lenses are supplied: **WARNING: IF YOU ARE HAVING ANY OF THE FOLLOWING SYMPTOMS, REMOVE YOUR LENSES IMMEDIATELY AND CONSULT YOUR EYE CARE PRACTITIONER BEFORE WEARING YOUR LENSES AGAIN: UNEXPLAINED EYE DISCOMFORT, WATERING, VISION CHANGE OR REDNESS.**

h) Applicant is required and agrees to fill contact lens prescriptions without deviation or substitution of lenses and according to the strict directions of a person who is either licensed to practice optometry or medicine and surgery in the State of Kansas; and

i) Applicant submits to the personal jurisdiction of the courts of the State of Kansas and the of the Kansas State Board of Healing Arts, and waives any claim that the Applicant does not have sufficient minimal contact with the State of Kansas or that the courts or the Kansas State Board of Healing Arts might lack personal jurisdiction in connection with any judicial or administrative action arising out of the dispensing of contact lenses by mail within the State of Kansas.

I, _____, hereby certify that I acknowledge the terms, conditions and requirements of Kansas law for dispensing contact lenses by mail, and that I certify compliance with those laws. I have carefully read the questions in the foregoing application and have answered them correctly and without reservation.

Signature: _____

Print Name: _____

Date: _____

11. Fees:
Contact lenses registration $150.00.

Make the fee payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

CREDIT CARD PAYMENT AUTHORIZATION

Please enter required information, sign and date at the bottom. Mail or fax form.

☐ DISCOVER NETWORK ☐ MasterCard ☐ AMERICAN EXPRESS ☐ VISA

CARD NUMBER

Verification Code

3-4 digit non-embossed number found on the card signature panel

Expiration Date

MO / YR

_____ / _____

Name (as it appears on the credit card): _____

Billing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Telephone Number: _____ - _____ - _____

Payment Amount $ _____ Purpose of Payment: _____ (e.g. renewal, application)

Applicant/Licensee Name: _____

I agree to pay the above amount per the card issuer agreement.

_____

Signature Date

Please Note: The information on this form is considered personal and not subject to disclosure under the Kansas Open Records Act.

office use only

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