RESPIRATORY PROVIDERSHIP APPLICATION-2016

Please fill out completely and return with fee.

- **Organization Name**:_____

  Address: _____

  2015 Providership Number: KRCS___ ___ ___

  Providership Type: (CIRCLE ONE) ☐ Hospital ☐ Organization

- Number of Operational Beds at your facility:_____
- **Contact Person**:_____
- **Email of Contact Person**:_____
- **Phone # of Contact Person**:_____
- Is the Contact Person in the Education Department or Respiratory Department?_____

Name of RRT involved in the planning:_____

- Attached a list of all April 2016-March 2017 CEUs you approved? (CIRCLE ONE) ☐ Yes ☐ No

FEES: According to the schedule listed below:

PLEASE MAKE THE DRAFTS PAYABLE TO KRCS, SEND TO ME AT THE below ADDRESS.

Bed size 1 – 149	$200.00
Bed size 150 – 250	$250.00
Bed size 251 and above	$300.00
Organization/Institution*	$350.00

**This is for colleges/medical centers with multiple campuses, etc*

Send to

KRCS
520 E. Berry
Rose Hill, Ks. 67133

Do not write below this line

Application Status _____ 2015 CEU List Attached_____

Amount Paid_____ Approval Email Sent_____