

Send to

520 E. Berry

Rose Hill, Ks. 67133

RESPIRATORY PROVIDERSHIP APPLICATION

Please fill out completely and return with fee.

* Organization Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Providership Number: KRCS\_\_\_ \_\_\_ \_\_\_

Providership Type: (CIRCLE ONE) Hospital Organization

* Application Year \_\_\_\_\_\_\_\_\_\_
* 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 CEUs you approved from the previous year, April-March? (CIRCLE ONE) Yes No

FEES: According to the schedule listed below:

***PLEASE MAKE THE DRAFTS PAYABLE TO KRCS, SEND TO ME AT THE ABOVE 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*

**I have read and understand the “Providership Guidelines” and the “Frequently Asked Questions (FAQ’s).” I understand that the KS CEU Evaluator upon approval by the KRCS reserves the right to cancel providership status if evidence of unethical or unprofessional actions by the providers is disclosed.**

**SIGNATURE OF PROVIDERSHIP EVALUATOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE SIGNED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do not write below this line

Application Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous CEU List Attached\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount Paid\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approval Email Sent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_