CABINET FOR HEALTH AND FAMILY SERVICES
Office of the Inspector General

OIG-20:365A, November 2022

Application for Registration to Provide Abortion-Inducing Drugs

- If you have questions regarding this registration form, please call (502) 564–7963.
- Please answer all questions completely and accurately. Supporting documentation must be attached. An incomplete or illegible application will be returned without being processed.
- A non-refundable fee in the amount of $155 for initial registration or annual renewal must accompany this application. Approval will not be issued without receipt of this fee.
- A renewal application and fee shall be submitted at least 30 days prior to the date of expiration of the current registration.
- Please return the application, required documents, and a non-refundable registration fee payable to the Kentucky State Treasurer to:

Cabinet for Health and Family Services
Office of Inspector General
Division of Health Care
275 E. Main St., 5 E-A
Frankfort, KY 40621

The undersigned hereby registers to provide abortion-inducing drugs subject to the requirements of KRS 216B.200 – 216B.210, 311.7731 – 311.7736, and 902 KAR 20:365.

A. Type of Application

☐ Initial Registration ☐ Annual Renewal Registration

☐ Change of Name ☐ Other Change

B. Identification

1. Physician Name _____

2. Business Street Address _____
   (P.O. Box without a street address is not acceptable.)

3. City/State/Zip _____

4. Telephone Number _____ Email Address _____

5. After Hours Number _____ Fax Number _____

C. Employer

1. List the name of the corporation, association, or partnership where you are employed.

   _____

2. Federal ID # _____ State Tax ID # _____

3. If a corporation, list the date and place of incorporation _____

   Attach a Certificate of Authority to do business in Kentucky if incorporated in another state.

4. If a corporation, attach copies of articles of incorporation and current by-laws.

5. President _____

6. Agent(s) _____
   (Individual(s) authorized to transact business with the Cabinet for Health and Family Services and upon whom all notices and orders shall be served. Include address if different from the above address. Please attach another sheet of paper if necessary.)

   Address _____ City, State, Zip _____

D. Management Agent (if different from owner)

Name _____

Street Address _____ City, State, Zip _____

E. Verification

I understand that I am required to report any change in the information provided within this application that affects my registration status to the Office of Inspector General and complete a new application at that time. I agree that this agency and all aspects of its operation shall be open at all times during regular business hours to allow state agency personnel entrance upon its premises for the purpose of inspection. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application shall result in the denial or revocation of registration.

_____ _____
Signature of Authorized Representative Title

_____ _____
Name (please print or type) Date

F. Protocols and Documentation

Protocols and documentation to be submitted with the initial registration application. *(Re-submission of these protocols and documents is not required as part of an updated application unless they are different from the original documents submitted at the time of initial registration.)*

The following documents must be received before your application is considered complete:

- Evidence that you are licensed to practice medicine and in good standing in Kentucky.
- A signed copy of the annual Dispensing Agreement Form required by KRS 216B.206(1)(c).
- A written protocol regarding follow-up appointments as required by KRS 216B.206(1)(m).
- A written protocol regarding handling complications or adverse events as required by KRS 216B.206(1)(n).
- If you do not have hospital admitting privileges, a copy of a current written associated physician agreement as required by KRS 216B.206(2) and 311.7734.
- If you have hospital admitting privileges, please provide the name of the hospital(s) in the county or contiguous county where abortion-inducing drugs will be provided: _____.

Attestation Statement Regarding Registration

(Read this statement carefully before signing.)

Based on my personal knowledge and belief, I attest that the responses on this statement regarding compliance with KRS 216B.200 – 216B.210, 311.7731 – 311.7736, and 902 KAR 20:365 related to my registration to provide abortion-inducing drugs are true and correct.

I, (Type or print your name) _____, a physician in good standing licensed by the Commonwealth of Kentucky, declare that:

- I meet the requirements to be a "qualified physician" as set out in KRS 216B.200(9).
- I will comply with the requirements of KRS 216B.206(1)(b), (d)-(l), (o), and (p).
- I am in compliance with KRS 216B.206(2) regarding admitting privileges or a written associated physician agreement.

I understand that the Kentucky Cabinet for Health and Family Services may conduct an onsite visit at any time to examine records to validate that the statements made above are true and correct.

Name _____
(Typed or Printed)

Signature _____
(Authorized Representative)

Title _____ Date _____