



**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 acknowledges 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.

