STATE BOARD OF HEALING ARTS
800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612
(785) 296-7413 / e-mail: KSBHA_DataRequests@ks.gov / Fax: (785) 368-7102 / www.ksbha.org

QUERY ORDER FORM

Organization: **Telephone:** **Fax:**

Name: **Email Address:**

Street Address: **City:** **State:** **Zip:**

The requested data will be provided in an Excel spreadsheet and sent via email.
Fee: $45 (please submit the required payment with this form)

QUERY OPTIONS (please check all boxes you are requesting for your report)

License Types:

[ ] (AT) Athletic Trainer
[ ] (DC) Chiropractic Doctor
[ ] (DO) Osteopathic Doctor
[ ] (DPM) Podiatric Doctor
[ ] (LRT) Radiologic Technologist
[ ] (MD) Medical Doctor
[ ] (ND) Naturopathic Doctor
[ ] Naturopathic Acupuncturist
[ ] (OT) Occupational Therapist
[ ] (OTA) Occupational Therapy Assistant
[ ] (PA) Physician Assistant
[ ] (PT) Physical Therapist
[ ] (PTA) Physical Therapist Assistant

[ ] (RT) Respiratory Therapist
[ ] (LAC) Licensed Acupuncturist
[ ] (CMN-I) Independent Certified Nurse Midwife
[ ] (TW) Telemedicine Waiver
[ ] Contact Lens Distributor

MD/DO Specific:
[ ] Institutional
[ ] Postgraduate Permit
[ ] Special Permit
[ ] Resident Active

License Status:
[ ] Active
[ ] Exempt
[ ] Inactive
[ ] Federal Active
[ ] Reentry Active

Sort Order:
[ ] Alphabetical
[ ] County
[ ] License Type
[ ] Zip Code
[ ] Other

Requested Fields: *The release of a complete mailing address is subject to approval by our General Counsel. Data provided may be limited or redacted.*

Mailing:
[ ] Address
[ ] County
[ ] Phone Number
[ ] Email Address

Business:
[ ] Address
[ ] County
[ ] Phone Number
[ ] Email Address

[ ] Year of Birth
[ ] License Number
[ ] Degree Date
[ ] Original License Date
[ ] License Expiration Date

[ ] Disciplinary Action (Y/N)
[ ] License Type
[ ] License Status
[ ] Specialization
Please List:

To order: submit this form by e-mail or fax.

YOU MUST CERTIFY:

( ) Neither I nor any person within our organization intends to, and will not: (A) Use any list of names or addresses contained in or derived from the records or information for the purpose of selling or offering for sale any property or service to any person listed or to any person who resides at any address listed; and will not (B) sell, give or otherwise make available to any person any list of names or addresses contained in or derived from the records or information for the purpose of allowing that person to sell or offer for sale any property or service to any person listed or to any person who resides at any address listed.

Signature Date: mm/dd/yyyy Printed name of person signing

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Submit the completed form to the Board. Payments are processed in order of date received.

CREDIT CARD INFORMATION:

Card Type: DISCOVER / VISA / AMERICAN EXPRESS / MasterCard		
Card Number:		
Expiration Date: (MM/YY)	**Verification Code:**	
Purpose of Payment: *(Application, NPDB, KBI, Verification of License Fee, etc.) To view license Fee List, click here.*		**Amount:**
Name of Cardholder:		

Mailing Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	

APPLICANT/LICENSEE INFORMATION:

Name of Applicant/Licensee:	**License Number:**

By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge the above-mentioned amount. I understand that failure to submit the required information will delay processing of the payment.

Cardholder Signature ______________________ Date ______________

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