TELEMEDICINE WAIVER GENERAL INFORMATION

Thank you for your interest in the Kansas Telemedicine Waiver. The Telemedicine Waiver is available for all healthcare professions regulated by the Kansas State Board of Healing Arts ("KSBHA"). **Those who hold a Telemedicine Waiver in Kansas shall be subject to all the rules and regulations pertaining to the practice of the licensed profession in this state and shall be considered a licensee for the purposes of the professional practice acts administered by the KSBHA. If you currently hold a Kansas license you do not need a separate Telemedicine Waiver to practice telemedicine in Kansas. If the Telemedicine Waiver is granted based on an unrestricted license in another state, you must maintain the active license and unrestricted status.**

The application and all forms are fillable PDFs and can be submitted electronically by emailing KSBHA_Licensing@ks.gov. If a seal or notary is required, it must be clearly visible to be accepted by email. **Pages 1-3 of the application will not be accepted handwritten.** KSBHA highly recommends that you make and keep copies of all the items you submit to the Board. As a reminder, **please do not make a commitment to work dates, prior to obtaining the waiver**.

Applications are processed in order of date received. After an application is processed, if something is identified as missing, a missing requirement letter ("MRL") is sent to the preferred email address. Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application. For updates, login to the online portal using the registration code listed in the MRL. When the waiver is issued, a notification with the wallet card is sent to the preferred email address.

If your waiver was issued before May 1, you will be required to renew during that year's renewal period. If your waiver is issued after May 1, you will not be required to renew until the following calendar year. Renewal begins May 15 of each year. All Telemedicine Waivers cancel August 1, if not renewed.

Fees:

Application**: $97**

NPDB: **$3**

ALL FEES ARE NON-REFUNDABLE

Requirements

- Currently hold a full, active, and unrestricted license in another state or meets the qualifications required under Kansas law to practice your profession.
- Not the subject of any investigation or disciplinary action by any applicable licensing agency.

Telemedicine Waiver Check List:

	Complete application with all questions answered.
	Notarize and sign the Affidavit and Authorization.
	Provide documentation for any "YES" answers to the Attestation Questions.
	Provide documentation of name change, if applicable.
	Complete and sign the Third-Party Release, if applicable.
	Physician assistants, complete the Active Practice Request Form and Written Agreement.
	Athletic trainers, complete the Athletic Trainer Practice Protocol.

TELEMEDICINE WAIVER APPLICATION

The Telemedicine Waiver is available for all healthcare professions regulated by the Kansas State Board of Healing Arts ("KSBHA"). **Those who hold a Telemedicine Waiver in Kansas shall be subject to all the rules and regulations pertaining to the practice of the licensed profession in this state and shall be considered a licensee for the purposes of the professional practice acts administered by the KSBHA. If you currently hold a Kansas license you do not need a separate Telemedicine Waiver to practice telemedicine in Kansas. If the Telemedicine Waiver is granted based on an unrestricted license in another state, you must maintain the active license and unrestricted status.** Completed application and forms can be emailed to KSBHA_Licensing@ks.gov or mailed to the KSBHA. If a seal or notary is required, it must be clearly visible to be accepted by email. **Pages 1-3 of the application will not be accepted handwritten.**

REQUIREMENTS

- Currently hold a full, active, and unrestricted license in another state or meets the qualifications required under Kansas law to practice your profession.
- Not the subject of any investigation or disciplinary action by any applicable licensing agency.

PROFESSION

Select the profession you intend to practice.

QUALIFYING LICENSE

List the license in which you would like to use to obtain the Telemedicine Waiver. If the Telemedicine Waiver is granted based on an unrestricted license in another state, you must maintain the active license and unrestricted status.

State	Type of License	License Number	Issue Date	Expiration Date

IDENTIFYING INFORMATION

Provide your full legal name. If the name on the application differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name.

First Name:	Middle Name:	Last Name:	Suffix:
List all other names used, including maiden name:			
Social Security Number:		Date of Birth: (MM/DD/YYYY)	
Place of Birth:		Male ___	Female ___

ADDRESSES

Addresses cannot be a Post Office Box, except qualified participants under the Safe at Home Act, K.S.A. 75-451 *et seq*. Your home address will not be available to the public. The business address is public and will be posted on the Board's website. The Board will contact you at the preferred address.

Home Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	
Business Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	
Preferred Address: (mailed and emailed correspondence will be sent to the selected address)		Home ___	Business___

LEGAL AUTHORITY TO WORK IN THE U.S.

Are you a US Citizen? ___ Yes ___ No If you answered NO, are you (check one):	
	A qualified alien (as defined in 8 U.S.C.A § 1641.
	A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A § 1101 *et seq*).
	An alien who is paroled into the United States under 8 U.S.C.A § 1182(d)(5) for less than one year.
	A foreign national, not physically present in the Unites States.
	Other:

NATIONAL PROVIDER IDENTIFIER (NPI)

The NPI is a unique 10-digit numeric identifier for health care professionals available from the Centers for Medicare and Medicaid Services ("CMS"). Provide your NPI number or if you do not have an NPI number check the corresponding box.

I do not have a NPI Number ___	NPI number:

POSTSECONDARY EDUCATION

List the professional school from which you graduated and were awarded a degree for your profession.

Name:			
City:	State:	Start Date:	End Date:
Degree Awarded:		Date Awarded:	

OTHER LICENSES/PERMITS/CERTIFICATIONS

List all states or jurisdictions in which you currently, or have ever held, a **healthcare related license, permit or certification, permanent or temporary.** Attach additional page if necessary.

Other than the Qualifying License, I have never held a healthcare related license, permit or certification in another state or jurisdiction. ___			
State	Issue Date	License Type	License Number

PROFESSIONAL LIABILITY INSURANCE & KANSAS HEALTH CARE STABILIZATION FUND '

MD, DO, DC, DPM, and PAs

For all new policies and policies that renew on and after January 01, 2022, K.S.A. 40-3402 requires **MD, DO, DC, DPM and PAs** with an active license in Kansas to maintain professional liability insurance of not less than $500,000 per claim, and not less than $1,500,000 annual aggregate for all claims made during the policy period. These professions are also required to maintain compliance with the Kansas Health Care Stabilization Fund (KHCSF). K.S.A. 40-3404; K.S.A. 65-2809(c); K.S.A. 65-2005(d); K.S.A. 65-28a03(b). For questions relating to how to comply with Fund requirements, please contact (785) 291-3777 or email HCSF@ks.gov.

PTs

K.S.A. 65-2920 and K.A.R 100-29-15 requires **PTs** practicing in Kansas to maintain professional liability insurance of not less than $100,000 per claim, and not less than $300,000 annual aggregate for all claims made during the policy period.

OTs

K.S.A. 65-5423 and K.A.R 100-54-13 requires **OTs** practicing in Kansas to maintain professional liability insurance. Individual coverage of not less than $100,000 per claim, subject to an annual aggregate of not less than $300,000 for all claims made during the period of coverage; **or** coverage through the individual's employer under an additional insured policy for which the limit is not less than $1,000,000 per claim, subject to an annual aggregate of not less than $3,000,000.

I am **not** an MD, DO, DC, DPM, PA, PT, or .	
I am an **OT** and certify that I have read and understand the professional liability insurance requirements and will maintain compliance.	
I am a **PT** and certify that I have read and understand the professional liability insurance requirements and will maintain compliance.	
I am a **MD, DO, DC, DPM, or PA** and certify that I have read and understand the professional liability insurance and KHCSF requirements and/or will contact the KHCSF to ensure compliance.	

ATTESTATION QUESTIONS

Please answer each of the following questions. **All "yes" answers MUST be thoroughly explained in detail on a separate, signed page.** You are required to furnish complete details including date, place, reason, and disposition of the matter and attach all relevant documentation. It is imperative you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.

1. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes___ No___
2. Have you ever voluntarily surrendered any professional license? Yes___ No___
3. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held? Yes___ No___
4. Do you have any physical or mental health condition (including alcohol or substance use) that currently impairs your ability to practice your profession in a competent, ethical, and professional manner? Yes___ No___
5. Have you ever surrendered your state or federal controlled substances registration, or had it revoked, suspended, or restricted in any way? Yes___ No___
6. Have you ever been convicted of a felony? Yes___ No___
7. Are you currently under investigation by any professional licensing agency or credentialing authority? Yes___ No___

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant: In the presence of a notary public, sign and date this form with attached photo. Email completed form to KSBHA_Licensing@ks.gov or mail directly to the Kansas State Board of Healing Arts.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the application for the practice of Telemedicine Waiver and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if a change occurs any time prior to a Telemedicine Waiver to practice my profession being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my Telemedicine Waiver to practice my profession.

Applicant Photograph

Attach a 2 x 3- inch color photograph of applicant, with head and shoulder areas only, taken within the last 90 days.

____
Applicant's signature (must be signed in the presence of a notary)

____
Applicant's printed first name middle initial, last name, and suffix (e.g., Jr.)

____
Date of signature (must correspond to date of notarization)

NOTARY

State of ____________________________, County of _________________________,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this ______day of ______, 20______

Notary Public Signature ____________________________________ My Notary Commission Expires ______________________

THIRD PARTY RELEASE

If you would like the Kansas State Board of Healing Arts ("Board") staff to talk with third parties about your application complete this form. This form provides authorization for the Board to release information regarding your application to third parties. This information includes, but is not limited to: application information, license verification, status change, address changes, Kansas Health Care Stabilization Fund information, continuing education information, audit information, and past or current legal issues and documents. This authorization expires one year from the date of signature. You can revoke this authorization at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to receipt of your written request. A reproduction of this authorization shall have the same effect as the original. Email to KSBHA_Licensing@ks.gov or mail it directly to the Board.

I, ____, authorize Board staff to release and discuss any and all information pertaining to my application, with the following individuals:

1. Name: ____________________________________
   Phone: ____________________________________
   Email: ____________________________________
   Relationship: ____________________________________

2. Name: ____________________________________
   Phone: ____________________________________
   Email: ____________________________________
   Relationship: ____________________________________

I acknowledge by my signature, that although I am not required to authorize the Board to release information to third parties, I am giving my consent for Board staff to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information which has already been released with consent, prior to my revocation.

____ ____________________________
Signature of Applicant Date

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.

Kansas State Board of Healing Arts
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www.ksbha.org