GENERAL INFORMATION - RESIDENT ACTIVE LICENSE

Thank you for your interest in becoming licensed in Kansas. Please read the following information carefully. This information is vital to the successful completion of your application and often, questions you may have, are covered. For all information governing the practice of Medicine and Surgery in Kansas, please visit the Statute and Regulation Handbook.

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 being licensed**.

Applications are processed in order of date received. Please allow **at least 2 to 4 weeks** for the processing of your application. 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 license is issued, a notification with the wallet card is sent to the preferred email address.

If your license is issued before May 1 , you will be required to renew during that year's renewal period. If your license is issued after May 15, you will not be required to renew until the following calendar year. Renewal starts May 15; late renewal starts July 1. All Resident Active licenses cancel August 1, if not renewed. Additionally, the license will cancel upon any of the following: resignation from the postgraduate program, being no longer in good standing in the postgraduate training program, or removal from the program. In the event you cease to be engaged or in good standing in the postgraduate program you must notify the Board within 7 business days.

Fees:
Application**: $100**
Background Check: **$57**
NPDB: **$3**
ALL FEES ARE NON-REFUNDABLE

Requirements:
(1) graduate of an accredited school of medicine (LCME or COCA);
(2) successfully completed 12 months of postgraduate training;
(3) presently engaged in and in good standing in an approved postgraduate training program;
(4) have passed step 3 of the USMLE (or Level 3 of COMLEX);
(5) have approval from your postgraduate training or residency program to provide services outside the parameters of postgraduate training program;
(6) maintain a policy of professional liability insurance required pursuant to K.S.A. 40-3402 and pay the premium surcharges as required by K.S.A. 40-3404.

Resident Active Application Check List:

☐	Complete application with all questions answered.
☐	Request official transcript with final medical degree awarded be sent directly to the board.
☐	Request USMLE/COMLEX scores be sent directly to the board.
☐	Request each postgraduate program you have attended complete the Postgraduate Training Verification.
☐	Request the postgraduate program you are currently engaged in complete the Statement of Medical Services.
☐	Request verification of other licenses, permits or certifications, if applicable.
☐	Provide proof of professional liability insurance.
☐	Provide documentation for any "YES" answers to the Attestation Questions.
☐	Provide documentation of name change, if applicable.

☐	Notarize and sign the Affidavit and Authorization.
☐	Complete and sign the Background Check Waiver and obtain fingerprints.
☐	Complete and sign the Third-Party Release, if applicable.

APPLICATION INSTRUCTIONS – RESIDENT ACTIVE

Application Fees: Application fees must be submitted with the application. These *fees are* ***non-refundable*** and will be processed upon receipt. The Kansas Resident Active application fee is **$100**. Also, a background check fee of **$57** and a National Practitioner Data Bank ("NPDB") report fee of **$3** must accompany the application. This totals **$160**. Board staff directly runs an NPDB report for all applicants. **Please do not submit an NPDB self-query.** To pay by debit or credit card, complete the Credit Card/Debit Card Authorization Form. Please make all checks payable to KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card.

Name: 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. Documentation is not required if it has been previously submitted.

Identification: Federal Law, at 42 U.S.C.S. § 666(a)(13), mandates that this agency record social security number on your application. K.S.A. 74-148(a) provides that every application by an individual for a professional license shall request the applicant's social security number. K.S.A. 74-139 requires this agency to disclose your social security number upon request to the Kansas director of taxation. Your social security number may be provided for child support enforcement actions, to the Kansas director of taxation, or for reporting disciplinary actions to the National Practitioner Data Bank-Health Integrity and Protection Data Bank (NPDB-HIPDB) as required by 45 C.F.R. §§ 61.1 *et seq*. Disclosure by this agency of your social security number is voluntary to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your social security number will not be released for any other purpose not permitted by law.

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. You may consider listing the postgraduate program as the business address. The Board will contact you at the preferred mailing and email address. If your address or contact information changes, you must notify the Board within 30 days by completing the Change of Address Form or in the Online Portal.

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. Provide your NPI number or if you do not have an NPI number check the corresponding box.

Examination: Select which licensing exam you have taken. List the number of attempts you have taken each portion and the date passed. Request an official copy of your exam scores be sent directly to the Board.

Medical Education: List all medical schools you have attended, even those from which you did not graduate. Attach an additional page if necessary. Request an **official transcript with the final medical degree awarded** be mailed or sent electronically from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors. Send electronic transcripts to KSBHA_Licensing@ks.gov. An official transcript is not required if one has been previously submitted.

Postgraduate Training: In chronological order, list all postgraduate programs you have attended, even those from which you did not complete. Attach additional page if necessary. Request each postgraduate program you've attended complete the Postgraduate Training Verification Form.

Employment/Professional History: In chronological order, list all healthcare employment/professional history since graduating medical school. Account for all months and explain all gaps. Attach additional page if necessary. Include the actual work address, not corporate headquarters. If you have not worked in a healthcare position since graduating medical school check the corresponding box.

Other Licenses/Permits/Certifications: List all state or jurisdictions in which you currently, or have ever held, a healthcare related license, permit, or certification, permanent or temporary. The Board will verify your credentials for any state or jurisdiction that provides free and current verifications on their official state website and includes the following information: issue date, expiration date, and any pending or past disciplinary action. If the Board is unable to verify your credentials, you may complete the Verification Form and forward to all licensing agencies. Please check with the licensing agency to see if a fee is required for this information prior to sending the form. The Board accepts electronic verifications directly from the licensing agency or their official third-party vendor. Send electronic verifications to KSBHA_Licensing@ks.gov. If you have never held a healthcare related license, permit, or certification in another state or jurisdiction check the corresponding box.

Professional Liability Insurance and Kansas Health Care Stabilization Fund Compliance: All new policies and policies that renew on and after January 1, 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.

Submit one of the following as proof of coverage (proof must include the insurance company's information, applicants name, coverage amounts, and coverage dates):

- Certificate of Insurance
- Letter of intent from the liability insurance company

The policy must cover medical services that will be provided outside of the postgraduate training program.

When the license is ready for approval:

- If the professional liability insurance is effective upon licensure approval or has a past effective date the license will be issued that day.
- If the professional liability insurance has a future effective date the license will be approved but will not be issued or become effective until the date the professional liability insurance goes into effect. Furthermore, the license effective date cannot be more than 90 days from the date the license is ready for approval. If at the time the license is ready for approval the professional liability insurance effective date is more than 90 days out, the license will not be approved, and you will be contacted to provide a policy with an updated effective date.

Attestation Questions: The mission of the Board is to protect the public which it does so in part, through effective licensure and enforcement. The public is safeguarded by issuing licenses to qualified, competent, and ethical applicants. In the application, you will be asked a series of attestation questions. A "yes" answer to an attestation question is not an automatic disqualification for licensure – each applicant is considered on an individual basis. **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. All information received will be checked accordingly to verify the truth and veracity of your answers. You may be requested to submit additional information or documents. It is your continued duty to update the Board on any changes once the application has been submitted. Please keep in mind, **failure to fully disclose may constitute grounds for denial of your application**.

Affidavit and Authorization for Release of Information: In the presence of a notary public, sign, and date this form. Photo must be 2 x 3-inchs, in color, of the head and shoulder area only, and taken within the last 90 days. Black and white photographs, proof photographs, negatives, photographs cut from books or newspaper articles, or poor-quality photographs are **NOT** accepted.

Postgraduate Training Verification: Complete, sign and date the top portion of the form. Request each postgraduate program you have attended complete the bottom portion and return directly to the Board. A seal or notary is required, and it must be clearly visible to be accepted by email. The Postgraduate Training Verification must be received directly from the program.

Statement of Medical Services: Complete, sign and date the top portion of the form. Request the postgraduate program director who is approving you to work outside the parameters of the postgraduate program complete the bottom portion and return directly to the Board. A seal or notary is required, and it must be clearly visible to be accepted by email. The Statement of Medical Services must be received directly from the program.

Waiver Agreement and FBI Privacy Act Statement: Complete, sign and date the top portion of the form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

Fingerprints: Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the **fingerprints must be printed on the fingerprint card** and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email KSBHA_Licensing@ks.gov or call (785) 296-7413. Be aware that fingerprint processing may delay your application. Please make it a priority to complete the fingerprint process.

Third Party Release: Complete this form if you would like Board staff to talk with third parties about your application.

How to Check the Status of Your Application: Once your application is received and processed, you will be notified via email of any missing items and how to check the status of your application online.

RESIDENT ACTIVE LICENSE APPLICATION

Completed application and forms can be emailed to KSBHA_Licensing@ks.gov or mailed to the Kansas State Board of Healing Arts. 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.** As a reminder, **please do not make a commitment to work dates, prior to being licensed.**

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. Documentation is not required if it has been previously submitted.

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. You may consider listing the postgraduate program as the business address. 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 an NPI Number ☐	NPI number:

EXAMINATION

Select which licensing exam you have taken. List the number of attempts you have taken each portion and the date passed. Request an official copy of your exam scores be sent directly to the Board.

Exam Taken: ☐ USMLE ☐ NBOME/COMLEX -USA ☐ NBME ☐ LMCC ☐ Other:				
	Part 1/Step 1/Level 1	Part 2/Step 2 CK/Level 2 CE	Part 2/ Step 2 CS/Level 2 PE	Part 3/Step 3/Level 3
Attempts				
Date Passed				

MEDICAL EDUCATION

List all medical schools you have attended, **even those from which you did not graduate**. Attach additional page if necessary. Request an official transcript with the final medical degree awarded be sent from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors. An official transcript is not required if one has been previously submitted.

Name of Medical School:			
City:	State:	Start Date:	End Date:
Degree Awarded:		Date Awarded:	

Name of Medical School:			
City:	State:	Start Date:	End Date:
Degree Awarded:		Date Awarded:	

POSTGRADUATE TRAINING

In chronological order, list all postgraduate programs you have attended, even those from which you did not complete. If in progress, list the expected completion date as the end date. Attach additional page if necessary. Request each postgraduate program you've attended complete the Postgraduate Training Verification Form.

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other:			
Name of Institution:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:			
Start Date:	End Date:	Successfully Completed? ☐ Yes ☐ No ☐ In progress	
Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other:			

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other:			
Name of Institution:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:			
Start Date:	End Date:	Successfully Completed? ☐ Yes ☐ No ☐ In progress	
Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other:			

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other:			
Name of Institution:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:			
Start Date:	End Date:	Successfully Completed? ☐ Yes ☐ No ☐ In progress	
Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other:			

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other:			
Name of Institution:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:			
Start Date:	End Date:	Successfully Completed? ☐ Yes ☐ No ☐ In progress	
Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other:			

EMPLOYMENT/PROFESSIONAL HISTORY

In chronological order, list all healthcare employment/professional history since graduating medical school. Account for all months and explain all gaps. Attach additional page if necessary. Include the actual work address, not corporate headquarters. If you have not worked in a healthcare position since graduating medical school check the corresponding box.

I have not worked in a healthcare position since graduating medical school ☐

Employer	Job Description/Title	Address	Start Date	End Date

OTHER LICENSES/PERMITS/CERTIFICATIONS

List all state or jurisdictions in which you currently, or have ever held, a **healthcare related license, permit or certification, permanent or temporary.** If you have never held a healthcare related license, permit or certification in another state or jurisdiction check the corresponding box. The Board will attempt to verify your credentials. If the Board is unable to verify your credentials you will be notified.

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 & FUND COMPLIANCE

All new policies and policies that renew on and after January 1, 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).

I certify that I have read and understand the professional liability insurance and KHCSF requirements and will maintain compliance while holding an active license in Kansas.	☐

U.S. ARMED FORCES SERVICE

U.S. Armed Forces Service: ☐ Yes ☐ No	Branch:	
Start Date:	End Date:	Type of Discharge:

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. All information received will be checked accordingly to verify the truth and veracity of your answers. **It is imperative you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

If you are unsure of your response to a question, check the "yes" box and submit the appropriate documentation. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty. Please be advised that a false response to any of these questions may be grounds for denial of licensure. If a question is not applicable, then check the "no" box.

Full Name of Applicant _____ Date _____

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program, excluding academic probation in medical school, prior to completing the training? Yes ☐ No ☐
2. Have you ever had any application for any professional license, registration, or certificate denied by any licensing authority? Yes ☐ No ☐
3. Have you ever been denied the privilege of taking an examination required for any professional license, registration, or certificate? Yes ☐ No ☐
4. While working in a healthcare facility as a staff member (including postgraduate training) did you ever have your privileges censured, limited, suspended, revoked, or received other disciplinary action? Yes ☐ No ☐
5. While working in a healthcare facility as a staff member (including postgraduate training) did you ever voluntarily or involuntarily resign while under investigation? Yes ☐ No ☐
6. Have you ever been denied privileges with any health care facility? Yes ☐ No ☐
7. Have you ever been requested to resign, withdraw, or otherwise terminate your position with a partnership, professional association, corporation, or other practice organization, either public or private? Yes ☐ No ☐
8. Have you ever voluntarily surrendered any professional license registration, or certificate, in lieu of formal disciplinary proceedings? Yes ☐ No ☐
9. Has any licensing authority ever limited, suspended, revoked, censured or placed you on probation, or have you had any other disciplinary action taken against any professional license, registration, or certificate you have held? Yes ☐ No ☐
10. Have you ever been requested to appear before a licensing authority? Yes ☐ No ☐

11. To your knowledge, have any complaints or charges ever been filed against you, or are you currently under investigation, with any licensing agency, professional association, or health care facility? Yes ☐ No ☐

12. Has any professional association imposed any disciplinary action against you? Yes ☐ No ☐

13. Do you currently have any physical or mental health condition (including alcohol or substance use) that impairs your ability to practice your profession in a competent, ethical, and professional manner? Yes ☐ No ☐

14. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate? Yes ☐ No ☐

15. Have you ever had your Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration revoked, suspended, or restricted in any way, or surrendered in lieu of formal proceedings? Yes ☐ No ☐

16. Have you ever been arrested? You must include all arrests including those that have been set aside, dismissed, expunged, pardoned, or where a stay of execution has been issued. Yes ☐ No ☐

17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation? You must include those that have been set aside, dismissed, pardoned, or expunged, or where a stay of execution has been issued. Yes ☐ No ☐

18. Have you ever been court martialed or dishonorably discharged from the armed services? Yes ☐ No ☐

19. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself? Yes ☐ No ☐

20. Have you ever been denied participation in any State Medicaid or Federal Medicare Programs, or in a private insurance company? Yes ☐ No ☐

21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any state or federal Medicaid or Medicare Programs, or private insurance company? Yes ☐ No ☐

It is your continued duty to update the Board on any changes once the application has been submitted.

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 Resident Active licensure 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 license to practice medicine 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 license to practice medicine.

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 _____

POSTGRADUATE TRAINING VERIFICATION

Applicant: Complete the top portion and submit to all postgraduate training programs you have attended.

Postgraduate Program: Complete the bottom portion and email to KSBHA_Licensing@ks.gov or mail directly to the Kansas State Board of Healing Arts. The seal or notary must be clearly visible to be accepted by email. Report incomplete years separately from those that were successfully completed. If in progress, list the expected completion date as the end date.

I hereby authorize the institution listed below to provide the Kansas State Board of Healing Arts any and all information pertaining to my postgraduate training at that institution.

Full Name: _____

Other Names Used: _____ Date of Birth: _____

Signature: _____ Date: _____

TO BE COMPLETED BY THE PROGRAM DIRECTOR, CLINICAL DIRECTOR, OR TRAINING SUPERVISOR

Name of Applicant: _____

Name of Sponsoring Institution: _____

Address: _____

Postgraduate Training Year: ___

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other: _____

Department/Specialty: _____

Start Date:_____ End Date:_____ Successfully Completed? ☐ Yes ☐ No ☐ In progress

Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other: _____

Postgraduate Training Year: ___

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other: _____

Department/Specialty: _____

Start Date:_____ End Date:_____ Successfully Completed? ☐ Yes ☐ No ☐ In progress

Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other: _____

Postgraduate Training Year: ___

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other: _____

Department/Specialty: _____

Start Date:_____ End Date:_____ Successfully Completed? ☐ Yes ☐ No ☐ In progress

Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other: _____

Postgraduate Training Year: ___

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other: _____

Department/Specialty: _____

Start Date:_____ End Date:_____ Successfully Completed? ☐ Yes ☐ No ☐ In progress

Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other: _____

If any "yes" answers, please provide a detailed explanation on a separate sheet.

1. Did this individual ever take a leave of absence or break from training? Yes ☐ No ☐
2. Was this individual ever placed on probation? Yes ☐ No ☐
3. Was this individual ever disciplined or under investigation? Yes ☐ No ☐
4. Were any negative reports for behavioral reasons ever filed by instructors? Yes ☐ No ☐
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes ☐ No ☐

By signing below, I certify under penalty of perjury under the laws of the State of Kansas that the information provided is a true and correct statement of the record of the above-named physician.

_____ _____
Signature Date

_____
Printed Name & Title (Seal)

_____
Email

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

STATEMENT OF MEDICAL SERVICES – RESIDENT ACTIVE LICENSE

Applicant: Complete the top portion and submit to the postgraduate training program director who is approving you to work outside the parameters of the postgraduate program for purpose of securing a resident active license.

Postgraduate Program Director: Complete the bottom portion and email to KSBHA_Licensing@ks.gov or mail directly to the Kansas State Board of Healing Arts. The seal or notary must be clearly visible to be accepted by email.

I hereby authorize the institution listed below to provide the Kansas State Board of Healing Arts any and all information pertaining to my postgraduate training at that institution.

Full Name: _____

Other Names Used: _____ Date of Birth: _____

Provide a detailed statement of the medical services to be provided beyond the parameters of the postgraduate training program.

Signature: _____ Date: _____

TO BE COMPLETED BY THE PROGRAM DIRECTOR

Name of Applicant: _____

Name of Sponsoring Institution: _____

1. Is the applicant presently engaged and in good standing in the postgraduate program? Yes☐ No☐
2. Has the applicant successfully completed at least one year of postgraduate training or within three weeks of successful completion? Yes☐ No☐

   Completion or Expected Completion Date: _____
3. Do you approve the above listed medical services to be provided by the physician beyond the parameters of the postgraduate training program? Yes☐ No☐

By signing below, I certify under penalty of perjury under the laws of the State of Kansas that the information provided is a true and correct statement of the record of the above-named physician. Furthermore, I certify in event the physician ceases to be engaged or is no longer in good standing in the postgraduate program, or if I permanently withdraw my approval for the physician to provide the medical services listed above, the Board will be notified within 7 business days.

_____ _____
Signature Date

_____
Printed Name & Title (Seal)

_____
Email

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

Kansas
State Board of Healing Arts

FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS

A criminal background check is required prior to issuance of licensure. Be aware that fingerprint processing may delay your application. **Please make it a priority to complete the fingerprint process.**

Following is the Waiver Agreement and FBI Privacy Act Statement. Please complete, sign and date the top portion of this form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Please visit https://www.nbinformation.com/locations/locationMap.php for a listing of fingerprinting locations.

Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the fingerprints must be printed on the fingerprint card and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email KSBHA_Licensing@ks.gov or call (785) 296-7413.

Complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submission. Include name, aliases, complete mailing address, social security number, citizenship, date of birth, and personal information (sex, race, height, weight, eyes, hair, place of birth). The spaces for OCA, FBI and MNU numbers can be left blank. Cards with missing or incomplete information will be rejected and must be resubmitted.

Mail the completed Waiver Agreement and fingerprint card to the Board. You may want to use a mailing service that allows for delivery confirmation.

Kansas State Board of Healing Arts
Attn: Licensing
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612
Phone: (785) 296-0934
Email: KSBHA_Licensing@ks.gov

Fingerprint results are valid for 6 months from the date received. Applications for licensure completed after the 6-month period will be required to submit a new Waiver Agreement, fingerprint card, and $57 fee.

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) Kansas State Board of Healing Arts to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. The fingerprints are authorized to be submitted under the authority of the National Child Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law (Pub. L.) 103-209 and Pub. L. 105-251. Pursuant to K.S.A. 22-4701 et seq., K.S.A. 22-5001, K.S.A 75-712i, and 2022 Kansas Laws Ch. 92, § 1 (Senate Sub. for H.B. 2495), the Authorized Recipient may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the above-referenced Authorized Recipient of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Authorized Recipient may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities until the criminal history background check is completed.

I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose of challenging the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. See 5 United States Code (U.S.C.) 552a(b); 28 U.S.C. 534(b);34 U.S.C. 40316, Article IV(c); 28 CFR 20.21(c), 20.33(d), 906.2(d); and 2022Kansas Laws Ch. 92, § 1 (Senate Sub. for H.B. 2495).

I understand that my fingerprints will be retained by the KBI and/or the Federal Bureau of Investigation if the Authorized Recipient participates in the state or national Rap Back program for continued suitability for being an employee, volunteer or contractor, or eligibility for any license, certification, registration, or adoption. The Rap Back program will notify the Authorized Recipient when there are updates to my criminal history record. Once I am no longer employed, a volunteer contractor, licensed, certified, registered, or seeking adoption, the Authorized Recipient shall request my fingerprints be removed from the state and/or national Rap Back program.

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of identification records and information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous federal statutes, hundreds of state statutes pursuant to Pub. L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub. L. 94-29; Pub. L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).
Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 U.S.C. 552a), the Authorized Recipient is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also requires federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted

information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses:
The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 U.S.C. 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:
The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness at no cost.

To Challenge Your Kansas Criminal History Record Information (CHRI)
You may also obtain a copy of your Kansas CHRI to review for accuracy and completeness, by submitting a set of your fingerprints, a letter requesting your criminal history record, and payment of the appropriate fee to the KBI. If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license, certification or registration, or adoption.

For further details, including the current fee, visit the following Internet website: http://www.kansas.gov/kbi/info/info_brochures.shtml then find the brochure named "Record Checks for Non-Criminal Justice Purposes".

To Challenge Your National Criminal History Record Information (CHRI)
To obtain a copy of your national CHRI, also known as the Identity History Summary, for review and challenge you must submit a set of your fingerprints and the appropriate fee to the FBI. The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34).

Information regarding this process may be obtained at: https://www.fbi.gov/services/cjis/identity-history-summary-checks.

DO NOT SEND THIS FORM TO THE FBI

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

I have ☐ ***OR*** have not ☐ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under K.S.A. 21-5903.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information about how to challenge my criminal records for accuracy and completeness.

Signature Date

Printed Name Date of Birth

Residential Address City State Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

Method of Verifying Identity: ☐ Driver's License ☐ State Issued ID Card ☐ Military ID Card ☐ Passport

State/Branch: _____ ID Number: _____

Agency Name: _____

Address:_____

Telephone: _____ Fax: _____

Name of Individual Verifying Identity:_____

APPLICANT: ***Please return all pages to the Authorized Recipient***

_____

AUTHORIZED RECIPIENT: ***1. Must maintain the original or arrange for KBI to maintain.***
2. Must provide a copy to the applicant.

DO NOT SEND THIS FORM TO THE FBI

LICENSE VERIFICATION FORM

Send to all states or jurisdictions in which you currently, or have ever, held a license, permit, or certification, permanent or temporary. Verification fees may be applicable and are the applicant's responsibility. Please contact individual boards to confirm fees. The applicant should complete the top section. The official state board should complete the bottom section and email to KSBHA_Licensing@ks.gov or mail it directly to the Kansas State Board of Healing Arts.

I, hereby authorize and request the state Board of _____ having control of any documents, records, and other information pertaining to me to furnish to the Kansas State Board of Healing Arts information including documents and/or records regarding charges or complaints filed against me or my license/registration; informal, pending, closed or any other pertinent information.

Full Name: _____

Other Names Used (if applicable): _____ Date of Birth: _____

License or Registration No.: _____ Issue Date: _____

Profession: _____

Signature: _____ Date:_____

Full Name of Licensee or Registrant: _____

License or Registration No.: _____ Status: _____

Issue Date: _____ Expiration Date: _____

License Method: _____ School: _____

DISCIPLINARY ACTIONS:

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? Yes ☐ No ☐ Unable to Divulge ☐

Have formal disciplinary proceedings been initiated against the applicant or applicant's license or registration by a disciplinary authority in your state? Yes ☐ No ☐ Unable to Divulge ☐

Comments: _____

Signature: _____ (SEAL)

Title: _____

State Board of: _____

Date: _____

Kansas State Board of Healing Arts
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www.ksbha.org

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

Kansas State Board of Healing Arts
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www.ksbha.org

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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