



## **KANSAS LICENSURE APPLICATION INSTRUCTIONS MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)**

Please visit [www.ksbha.org](http://www.ksbha.org) for all statutes and regulations

### **Completing the Kansas Licensure Application**

Review the following instructions carefully before completing the application. This information is vital to the successful completion of your application. Failure to submit all required information and documentation will result in processing delays. Please allow two (2) weeks after the submission of the application before contacting our office. **Do not make a commitment to any work dates prior to being licensed.**

Kansas does not have direct reciprocity with any state. All applicants are considered on an individual basis. You may be requested to submit information or documentation in addition to the requirements mentioned herein before the application will be deemed complete. **It is highly recommended you make and keep copies, for your records, of all items submitted for review.**

In completing the application, you will be asked to account for all time since medical school graduation and list all **Malpractice Liability Claims Information**. Having this information on hand before you begin your session will facilitate completing your application.

If you have any questions about the information provided to you in the application packet, please contact our office at 785/296-7413. Thank you for applying for licensure in the State of Kansas.

### **The Federation Credentials Verification Service (FCVS)**

The Board accepts the use of FCVS as part of the licensure process. FCVS staff creates a permanent profile of primary source verified documents related to identity, medical education, postgraduate training, and more. The profile can be updated as needed and sent to boards and other entities without the need to verify each item again.

**Applicants using FCVS to verify their credentials are still required to complete the Kansas State Board of Healing Arts Uniform Application (UA).** If you do not use FCVS, you must provide your credentials to the Board for verification along with completing the UA.

For clarification, the Uniform Application (UA) is used to apply for state licensure. The FCVS application is used only to create or update a personalized profile of primary source verified credentials for use in the overall licensing process.

To use FCVS, visit <http://www.fsmb.org/> and select "FCVS" in the Licensure or Sign In menu, then sign in and continue as directed. Users with existing FCVS profiles should complete a Subsequent FCVS Application to ensure the profile is up to date. New FCVS users should complete the Initial FCVS Application. All users must, during the application process, designate the Kansas State Board of Healing Arts to receive the FCVS profile. Self designations are not accepted.

More information about FCVS is available at <http://www.fsmb.org/licensure/fcvs/>. For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT on weekdays.

## **The Uniform Application for Physician State Licensure (UA)**

This packet contains a version of the UA that can be completed and mailed to the Board instead of completing the UA online. There is no fee for using the paper UA.

Please note the following:

- The Board requires that you submit your valid National Provider ID number in the space provided.
- Accepted examinations are the United States Medical Licensing Examination ("USMLE") and the Comprehensive Osteopathic Medical Licensing Examination of the United States ("COMLEX-USA") or substantial equivalents approved by the Board. See Board Policy #21-04. Applicants must complete all steps within seven total attempts. See Board Policy #23-02.
- List all professional licenses (nurse, EMT, physician assistant, etc.) you have held in the U.S. or Canada, regardless of status (active, inactive, etc.). If you hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper to the Board. Use the Licensure Verification form in this packet to request license verifications from each board.
- On the Chronology of Activities, for military or locum tenens assignments, list each location/assignment separately. Additionally, for military service, please provide a copy of your discharge or separation documents.
- For all locations where you have had admitting privileges, check the "Staff Privileges" box.
- For all malpractice, claims include a written statement from the insurance company or insurance / personal / institution attorney. Include date of occurrence, name of the insurance company involved on your behalf, name of claimant(s), other defendant(s) and/or institution involved, list of all attorneys involved, case number and location of filing, status of the matter, and summary of the occurrence; or you may provide court documents. Failure to provide complete information will result in delay of processing the application.

In addition to completing the core UA, all applicants must:

- Complete the Expedited Licensure Questionnaire, License Designation, Attestation Questions, Criminal Background Waiver, and fingerprints.
- Submit a notarized UA Affidavit and Authorization for Release of Information form to the Board. This is a separate form from the FCVS Affidavit and must be sent to the Kansas State Board of Healing Arts. Attach a recent (less than 6 months old) two inch by two inch (2" x 2") passport-type color photograph of yourself in the space provided. Proof photos, negatives, and digital photos are not acceptable.
- KSBHA will verify each of your medical board licenses except for any board that does not provide free, current verifications and disciplinary actions on their official website. For those boards, use the licensure verification resource at <http://www.fsmb.org/licensure/uniform-application/> to determine the fees and preferred verification method of each board. Use the Licensure Verification form in this packet for boards requiring a written request. You may use VeriDoc or another preferred method if applicable.

If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education, Postgraduate Training, or Fifth Pathway Verification forms, or send identity documents, transcripts, certificates, or examination scores to the Board. FCVS obtains this information and sends it to the Board as part of your FCVS profile of verified credentials.

If you are not using FCVS for credentials verification,

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if your name is not the same on all of your submitted documents.
- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form.
- 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](mailto:KSBHA_Licensing@ks.gov).
- Contact each appropriate examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at <http://www.fsmb.org/licensure/uniform-application/faq>.
- An ECFMG Certification Status Report is required for all international medical graduates (“IMG”). Request a Certification Status Report be sent directly to the board by visiting <https://cvsonline2.ecfmg.org/>. Canadian graduates are not required to submit an ECFMG Status Report.
- If you attended a Fifth Pathway Program, request that the Fifth Pathway Program Certificate be sent to the Board.

### **Additional Licensure Information / Requirements**

- **Application Fee.** The Kansas application fee is **\$300**. Also, a background check fee of **\$47** and a National Practitioner Data Bank (“NPDB”) report fee of **\$3** must accompany the application. This totals **\$350**. It must be submitted with the application and is **NOT** refundable. 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.
- **AMA and AOIA Profile Reports.** MDs must request the AMA report from the American Medical Association at <https://profiles.ama-assn.org/amaprofiles/> or call 800-665-2882. DOs must request the AOIA report from the American Osteopathic Information Association at <https://www.doprofiles.org> or call 800-621-1773 x8145.
- **Criminal Background Report.** Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. Addendum 4 explains in detail how to obtain and submit your fingerprints to the Board. **Be aware that fingerprint processing may delay your application. Please make it a PRIORITY to complete the fingerprint process. Complete, sign and return the Waiver Agreement and Statement form directly to the Board. Applicants will be required to submit the completed waiver and \$47.00 fee.**
- **License Renewals.** MD licenses expire on July 31 and are renewed annually. License renewal will be required of all MD applicants receiving permanent licenses prior to May 1. DO licenses expire on October 31 and are renewed annually. License renewal will be required of all DO applicants receiving permanent licenses prior to August 1.

## UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE CHECKLIST

After completing the Uniform Application, you are responsible for submitting certain documents. There are two checklists below; one to use if you are using the Federation Credentials Verification Service (FCVS) and one to use if you are not using FCVS. Please use the checklist that applies to you.

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed Uniform Application (UA).	<input type="checkbox"/>	<input type="checkbox"/>
Completed state addenda and fees (Application - <b>\$300</b> , National Practitioner Data Bank Report <b>\$3</b> , KBI Fee <b>\$47</b> ) sent to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Notarized UA Affidavit and Authorization for Release of Information form sent to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Request verification of other licenses permits or certifications, if applicable. The Board will verify your credentials for any state or jurisdiction that provides free and current verifications on their official state website. If the Board is unable to verify your credentials, complete the Verification Form and forward to all licensing agencies.	<input type="checkbox"/>	<input type="checkbox"/>
American Medical Association or American Osteopathic Information Association report sent to the Board from the AMA or AOIA.	<input type="checkbox"/>	<input type="checkbox"/>
Completed Background Check Waiver, Fingerprint card, <b>\$47</b> Fee.	<input type="checkbox"/>	<input type="checkbox"/>
Supporting documentation of any legal name change sent to the Board.	<input type="checkbox"/>	Completed via FCVS
Medical Education Verification form sent to the Board from all medical schools attended.	<input type="checkbox"/>	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school(s).	<input type="checkbox"/>	Completed via FCVS
Medical School Diploma sent to the Board by your medical school(s).	<input type="checkbox"/>	Completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended, even from those you have not completed.	<input type="checkbox"/>	Completed via FCVS
Fifth Pathway form (if applicable) sent to the Board from the medical school and institution - include a copy of your diploma (must be sealed by your school).	<input type="checkbox"/>	Completed via FCVS
Examination Transcripts sent to the Board.	<input type="checkbox"/>	Completed via FCVS
ECFMG Status Report (if applicable) sent to the Board.	<input type="checkbox"/>	Completed via FCVS



## EXPEDITED LICENSURE QUESTIONNAIRE

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To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406<sup>i</sup>, please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military/law enforcement agencies.

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1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes  No  If yes:

Branch: \_\_\_\_\_ Dates of Service: \_\_\_\_\_ Military ID#: \_\_\_\_\_

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes  No  If yes:

Branch: \_\_\_\_\_ Dates of Service: \_\_\_\_\_ Military ID#: \_\_\_\_\_

3. Do you currently reside in Kansas? Yes  No  If yes:

Current Kansas Residence Address: \_\_\_\_\_

4. If you do not currently reside in Kansas, do you intend\* to establish residency in Kansas within the next 6 months?  
*\*If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military agencies in other jurisdictions.* Yes  No  If yes:

Intended Kansas Residence Address: \_\_\_\_\_

Expected Date of Commencing Residence: \_\_\_\_\_

**If you answered "no" to all questions #1 through #4, you do not need to answer questions #5 through #7.**

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. *This does not include certifications or registrations issued by private boards, professional societies, or any organization other than a government body of a state, district, or territory of the U.S.* Yes  No  If no:

a. Have you practiced the profession for which you are seeking licensure in Kansas for at least 3 years in a state that does not license/register/certify the profession? Yes  No

b. Have you practiced the profession for which you are seeking licensure in Kansas for at least 2 years in a state that does not license/register/certify the profession and you held a certification or registration issued by a private organization during those 2 years? Yes  No  If yes:

Organization that issued private certification/registration: \_\_\_\_\_ Date Issued: \_\_\_\_\_



\* “Active practice” does not include care provided while in a training program, residency, or fellowship; or employment that consisted solely of research activities or administrative duties. The Board generally considers active practice to be direct patient care that for either (1) at least one full day per week for 50 weeks during a year; or (2) 400 hours during a year.

6. Have you actively practiced\* the profession for which you are seeking licensure in Kansas during the last 2 years?  
Yes  No

**If you answered “yes” to question #6, you do not need to answer question #7.**

7. If you answered “No” to questions #6, please provide a detailed explanation regarding your active clinical practice and direct patient care during the 12 months immediately preceding the submission of your application. Please explain any gaps in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

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<sup>i</sup> An applicant who has not been in the active practice of their occupation during the two years preceding the application for which a license is sought, may be required to complete additional testing, training, monitoring or continuing education as the KSBHA deems necessary to establish present ability to practice in a manner that protects the health and safety of the public K.S.A. 48-3406(d).



## LICENSE DESIGNATION

**Please note: If you have NOT practiced medicine and surgery in the last two-years and you wish to engage in the active practice, under K.A.R. 100-6-6, you must select the Reentry Active license designation and submit a proposed reentry plan. For all information regarding the Reentry Active license designation see K.A.R. 100-6-6 in the [Healing Arts Practice Handbook](#).**

### LICENSE DESIGNATION

Read each description and select the appropriate designation.

<input type="checkbox"/> Active	Engaged in the practice of medicine and surgery. Required to complete continuing education, maintain professional liability insurance, and be compliant with the Kansas Health Care Stabilization Fund.
<input type="checkbox"/> Federal Active	Engaged in the practice of healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Required to complete continuing education. <b>Not</b> required to have professional liability insurance or be compliant with the Kansas Health Care Stabilization Fund.
<input type="checkbox"/> Reentry Active	Under an approved reentry plan, reentering the active practice of medicine and surgery. Required to complete continuing education, maintain professional liability insurance, and be compliant with the Kansas Health Care Stabilization Fund.
<input type="checkbox"/> Exempt	Does <b>not</b> regularly engage in the practice of healing arts and does not hold oneself out to the public as being professionally engaged in such practice. Entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. May perform administrative functions. <b>Not</b> required to maintain continuing education, maintain professional liability insurance, or be compliant with the Kansas Health Care Stabilization Fund.
<input type="checkbox"/> Inactive	<b>Not</b> engaged in the practice of the healing arts and does not hold oneself out to the public as being professionally engaged in such practice. <b>Not</b> required to maintain continuing education, maintain professional liability insurance or be compliant with the Kansas Health Care Stabilization Fund.

### PROFESSIONAL LIABILITY INSURANCE & FUND COMPLIANCE (Active License and Reentry Active License types only)

For 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 or reentry 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\(b\)](#).

**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 or employer



**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.

I certify that I have read and understand the professional liability insurance and KHCSF requirements and will maintain compliance while holding an active or reentry active license in Kansas.	—
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**PROPOSED REENTRY PLAN** (Reentry Active License Only)

Any physician who has not engaged in the practice of healing arts in the last two years must submit a proposed reentry plan for board review. Upon meeting all licensure requirements and approval of the reentry plan a Reentry Active license will be issued. While holding a reentry active license the physician shall not practice outside the scope of the approved reentry plan.

**The reentry plan shall contain the following:**

- (1) Name of the supervising physician, who is approved by the board;
- (2) An assessment of the physician’s current strengths and weaknesses in the intended area or areas of practice. The assessment may include testing and evaluation by colleagues, educators, or others; and
- (3) An education component that addresses the physician’s area or areas of needed improvement, if any, and consists of a reentry period of monitored practice and education upon terms based on the factors listed in K.A.R. 100-6-6(c).

**EXEMPT PROFESSIONAL ACTIVITIES** (Exempt License Only)

Select all professional activities you intend to engage in.

<input type="checkbox"/> Administration	<input type="checkbox"/> Charitable Health Care Provider	<input type="checkbox"/> Consultant
<input type="checkbox"/> Coroner/Deputy Coroner	<input type="checkbox"/> Paid Employee of Local Health Department	<input type="checkbox"/> Paid Employee of an Indigent Health Care Clinic
<input type="checkbox"/> Treatment of Family and Friends with No Compensation		
<input type="checkbox"/> Other:		

**PRIMARY SPECIALTY AND BOARD CERTIFICATION**

Primary Specialty:	
Board Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, are you Board eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No
Board Certification:	Board Certification:





## 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 martialled 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.\****



## FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS

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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](mailto: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](mailto: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 \$47 fee.

**WAIVER AGREEMENT  
AND  
FBI PRIVACY ACT STATEMENT**

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) **The 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 2022 Kansas 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.

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**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

**WAIVER AGREEMENT  
AND  
FBI PRIVACY ACT STATEMENT (Cont.)**

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).

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**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.

Alternatively, you may obtain a copy of your **Kansas criminal history record information** (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. For further details, including the current fee, visit the following Internet website: [http://www.kansas.gov/kbi/info/info\\_brochures.shtml](http://www.kansas.gov/kbi/info/info_brochures.shtml) then find the brochure named "Record Checks for Non-Criminal Justice Purposes". Or, to provide official court documents to make a correction you may write to:

Kansas Bureau of Investigation  
Attn: Criminal History Records  
1620 SW Tyler  
Topeka, Kansas 66612-1837

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.

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. Information regarding this process may be obtained at: <https://www.fbi.gov/services/cjis/identity-history-summary-checks>. Or, you may write to:

**WAIVER AGREEMENT  
AND  
FBI PRIVACY ACT STATEMENT (Cont.)**

FBI CJIS Division  
Attn: Criminal History Analysis Team 1  
1000 Custer Hollow Road  
Clarksburg, West Virginia 26306

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). The Authorized Recipient must submit a new set of fingerprints and fee to receive the updated federal criminal history record.

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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:

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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

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**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: \_\_\_\_\_

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



**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](mailto: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 Physician 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 \_\_\_\_\_



**Medical School Verification (UA Form #2)**

Applicant: Complete this form as instructed in the left sidebar.

Dean or Designated Med School Official: Complete as instructed in the left sidebar.

**Applicant:**

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

**Section 1: Applicant Information**

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Name of medical school: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

**Waiver for Release of Information:** I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts

Mailing address: 800 SW Jackson, Lower Level – Suite A

City/State/Zip: Topeka, KS 66612

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Dean or Designated Official:**

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the Kansas State Board of Healing Arts at the address listed in Section 1. **Do not mail this form to FCVS/FSMB.**

If transcripts are not in English, an original, certified, and official English translation is required.

**Section 2: Medical School Verification**

Medical school name: \_\_\_\_\_

School name if different when the above applicant attended: \_\_\_\_\_

Medical school address (including city, state or province, zip code, and country as applicable):  
\_\_\_\_\_  
\_\_\_\_\_

Hours of undergraduate education required for admission into your school: \_\_\_\_\_

Total weeks of education applicant attended your school: \_\_\_\_\_

Applicant's attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Graduation date: \_\_\_\_\_ Degree: \_\_\_\_\_  
(indicate N/A if not applicable) (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.



**Applicant Name:** \_\_\_\_\_

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes  No

If yes, please select the reason(s), indicate the dates of the interruption(s) or extension(s), and indicate whether the interruption(s)/extension(s) was/were approved or unapproved.

	From Month/Year	To Month/Year	Approved	Unapproved
<input type="checkbox"/> Personal/Family	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Academic remediation	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Health	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Financial	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in joint degree program (e.g., MD/PhD)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in non-research special study (e.g., fellowship, international experience)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes  No

If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
<input type="checkbox"/> Academic probation	_____	_____
<input type="checkbox"/> Probation for unprofessional conduct/behavioral reasons	_____	_____
<input type="checkbox"/> Probation for other reason(s) (please specify): _____	_____	_____

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes  No

If yes, please attach documentation/information of the circumstances and outcome(s).

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Yes  No

If yes, please attach documentation/information of the circumstances and outcome(s).

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes  No

If yes, please attach documentation/information of the nature of the limitations or special requirements.

**I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.**

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Email: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)



### Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.

Program Director or Designated Official: Complete as instructed in the left sidebar.

**Applicant:**

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

**Section 1: Applicant Information**

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Name of postgraduate training program: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

**Waiver for Release of Information:** I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts  
Mailing address: 800 SW Jackson, Lower Level – Suite A  
City/State/Zip: Topeka, KS 66612

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Dean or Designated Official:**

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

**Section 2: Postgraduate Training Verification**

Institution name: \_\_\_\_\_

Institution address: \_\_\_\_\_

Institution city / state or province / zip code: \_\_\_\_\_

Affiliated medical school name: \_\_\_\_\_

Institution / school name if different when the applicant attended: \_\_\_\_\_

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship

Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

**Applicant Name:** \_\_\_\_\_

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship  
 Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship  
 Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

**Unusual Circumstances**

- 1. Did this individual ever take a leave of absence or break from his/her training?  Yes  No
- 2. Was this individual ever placed on probation?  Yes  No
- 3. Was this individual ever disciplined or placed 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

**I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.**

Signature: \_\_\_\_\_  
Print name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_  
Email: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE  
(If no seal is available, this form must be notarized.)



**Fifth Pathway Verification (UA Form #4)**

Applicant: Complete this form as instructed in the left sidebar.

Program Director or Designated Official: Complete as instructed in the left sidebar.

**Applicant:**

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to your Fifth Pathway director.

**Section 1: Applicant Information**

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when certificate awarded: \_\_\_\_\_

Name of medical school: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

**Waiver for Release of Information:** I authorize the Program Director or designated official of the Fifth Pathway program to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts  
Mailing address: 800 SW Jackson, Lower Level – Suite A  
City/State/Zip: Topeka, KS 66612

**Applicant signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Program Director or Designated Official:**

Please complete all of Section 2. Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

**Section 2: Fifth Pathway Verification**

Institution name: \_\_\_\_\_

Institution address: \_\_\_\_\_

Institution city / state or province / zip code: \_\_\_\_\_

Institution / school name if different when the applicant attended: \_\_\_\_\_

Enrollment dates: From \_\_\_\_\_ to \_\_\_\_\_

Completed?  Yes. Certification date: \_\_\_\_\_  
 No. Withdrawal date: \_\_\_\_\_  
 No. Dismissal date: \_\_\_\_\_  
 In progress. Expected completion date: \_\_\_\_\_

If the applicant withdrew or was dismissed, please explain in the space below. Attach additional information if needed.

**Applicant Name:** \_\_\_\_\_

Type of Clinical Rotation	From	To	Number of Weeks Credit
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Unusual Circumstances**

- 1. Did this individual ever take a leave of absence or break from his/her training?  Yes  No
- 2. Was this individual ever placed on probation?  Yes  No
- 3. Was this individual ever disciplined or placed 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

Please explain any "Yes" response in the blank space below. Attach additional information if needed.

**I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.**

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Email: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)



**THIRD PARTY RELEASE**

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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](mailto:KSBHA_Licensing@ks.gov) or mail it directly to the Board.

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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:

<b>Card Type:</b> <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 			
<b>Card Number:</b> _____			
<b>Expiration Date:</b> (MM/YY) _____	<b>Verification Code:</b> _____		
<b>Purpose of Payment:</b> _____ <small>(Application, NPDB, KBI, Verification of License Fee, etc.) To view license Fee List, <a href="#">click here.</a></small>	<b>Amount:</b> _____		
<b>Name of Cardholder:</b> _____			
<b>Mailing Address</b>	Street Address: _____		
	City: _____	State: _____	Zip: _____
	Phone: _____	Email: _____	

### APPLICANT/LICENSEE INFORMATION:

<b>Name of Applicant/Licensee:</b> _____	<b>License Number:</b> _____
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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.