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. Do not send original forms or documentation to the Board.**

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/](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/](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)

Much like FCVS, after using the core UA to apply for licensure, you can submit the same core application to another UA using board, provided that the board specific requirements are also met and the UA is up to date. Using the UA eliminates data entry redundancy and provides significant time savings. There is a one-time fee of $50 gathered when submitting the UA for the first time.

To use the UA, go to http://www.fsmb.org/ and select “Uniform Application” from the Licensure menu or Sign In menu. A state board must be selected each time the UA is used. Submit your UA to the Board when you have finished.

The UA FAQ at https://www.fsmb.org/licensure/uniform-application/faq answers the most common UA questions. If your question or issue isn’t listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org with your username, a description of what you were doing at the time, and a screenshot or photo of an error if you see an error.

Please note the following:

- Provide both your current home address and current business practice/training address, otherwise an error will occur. Do not enter the same address for both home and work.

- The Board requires that you submit your valid National Provider ID number in the space provided.

- Accepted examinations are National Boards (NBME, NBOME), FLEX, USMLE, State Examinations, LMCC, COMLEX, or a combination of FLEX, USMLE, and National Boards. Applicants who took the FLEX prior to June 1985 must have passed with a FLEX weighted average of 75 or higher, attained in one sitting. Applicants who took the USMLE must complete all steps within 10 years.

- You are not able to add or edit MD and DO licenses in the UA as that data is provided directly into our system from the state boards. If you see incorrect or missing medical license information in your UA, email ua@fsmb.org with the correct information if changes are needed. Do not select “Other” to add a license unless it is for a professional non-medical license. The updated information should appear within 2 business days.

- 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 state addendum.

- 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.
Please note that by signing the Affidavit and Authorization for Release of Information form, you agree to the following:

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry in the state of Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years for each violation. (K.S.A. 21-3805)

- 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.

- Submit a notarized copy of your medical school diploma(s). The diploma(s) must be notarized as a true and accurate copy of the original. Note: Diplomas in languages other than English must be translated and the translation certified as accurate. Documents without such certification will not be accepted.

- 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.

- International Medical Graduates: Submit a notarized copy of your ECFMG Certificate to the Board. It must be notarized as a true and accurate copy of the original. Also request that a “Status Report of ECFMG Certification” be sent directly to the board. If you attended a Fifth Pathway Program, request that the Fifth Pathway Program Certificate be sent to the Board. See the UA FAQ link above for contact information.

**Additional Licensure Requirements**

- **Application Fee.** The Kansas application fee is $300.00. It must be submitted with the application and is NOT refundable. You may pay by check, debit card, Visa, MasterCard, Discover, American Express or money order. Make checks payable to KSBHA. Checks returned for any reason by the payer’s financial institution must be replaced by a money order, certified check, debit card or credit card.

- **AMA and AOIA 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 5 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.

• **National Practitioner Data Bank Report.** Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank (NPDB). This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments.

  The Kansas State Board of Healing Arts will obtain a NPDB report for all applicants. Applicants will be required to submit the report fee of $3.00 to the Board.

**Additional Licensure Information**

• **License Renewals.** MD licenses expire on June 30 and are renewed annually. License renewal will be required of all MD applicants receiving permanent licenses prior to April 1. DO licenses expire on September 30 and are renewed annually. License renewal will be required of all DO applicants receiving permanent licenses prior to July 1.

• **UA Checklist.** Use the checklist on the next page to ensure you complete each part of the licensure process.
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.

<table>
<thead>
<tr>
<th>Document Required</th>
<th>NOT using FCVS to verify credentials</th>
<th>Using FCVS to verify credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed online Uniform Application (UA).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed state addenda and fees (licensure fee of $300 plus National Practitioner Data Bank Report fee of $3) sent to the Board.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Notarized UA Affidavit and Authorization for Release of Information form sent to the Board.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>UA Licensure Verification form sent to the Board from each state board through which you have ever held any physician license if KSBHA is unable to verify the license.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>American Medical Association or American Osteopathic Information Association report sent to the Board from the AMA or AOIA.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Fingerprint card.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notarized copy of birth certificate or current, valid passport sent to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Supporting documentation of any legal name change sent to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Medical Education Verification form sent to the Board from all medical schools attended.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Medical School Transcripts sent to the Board by your medical school(s).</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Notarized copy/copies of medical school diploma sent to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Postgraduate Training Verification form sent to the Board from all programs you attended.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Copy of your postgraduate training certificate(s) sent to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>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).</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Examination Transcripts sent to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>ECFMG Status Report (if applicable) sent to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Notarized copy of ECFMG Certificate (if applicable) sent to the Board.</td>
<td>☐</td>
<td>Completed via FCVS</td>
</tr>
</tbody>
</table>
KANSAS LICENSURE APPLICATION ADDENDUM INSTRUCTIONS
MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Addendum

Complete each addendum as instructed. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Kansas State Board of Healing Arts at the address above.

☐ Addendum 1  These questions must be completed by the applicant.

☐ Addendum 2  Each question must be completed by the applicant. Documentation must be provided for any “yes” answer(s). It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.

☐ Addendum 3  The applicant’s full name and date of birth should be printed in the spaces provided on both pages. Two (2) recommendations by licensed physicians that can attest to the applicant’s good moral character, and who have known the applicant for at least one year are required. The completed forms must be returned directly to the Board. Two (2) forms have been provided for your convenience.

☐ Addendum 4  This form must be completed by the applicant. All applicants for licensure in the State of Kansas must request a disciplinary inquiry report from the Federation of State Medical Boards (FSMB). Once this form has been completed, you may email it to the FSMB at boardinquiry@fsmb.org.

If you are using FCVS, do not complete this form. They will obtain your disciplinary report and send it to the Board.

☐ Addendum 5  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 5 explains in detail how to obtain and submit 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.

☐ Credit Card Payment Authorization Form  This form should be used by applicants for payment of the Kansas application fee by credit card. Please enter the required information and return the form directly to the Board at the address above.
ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

Select the discipline applying for and the license designation being requested.

☐ Medicine & Surgery  ☐ Osteopathic Medicine & Surgery

☐ Active
A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

☐ Federal Active
A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the 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. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ Inactive
A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

☐ Exempt
A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is 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. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

List intended professional activities:

Additional Information and Statement of Health:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☐ No

2. Give location of intended practice in Kansas ______________________________________________________

3. Primary Specialty __________________________________________________________

American Board Certified __________________________ American Board Eligible _____________________

4. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your particular branch of the healing arts or your particular specialty? ☐ Yes ☐ No

If yes, applicant shall file with this application a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.
ADDENDUM 2
KANSAS STATE BOARD OF HEALING ARTS

Please answer each of the following questions by putting a check (✔) in the appropriate box. All “yes” answers MUST be thoroughly explained in detail in 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 that 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 particular question, check (✔) the “yes” box and submit the appropriate form if required. 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, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check (✔) the “no” box. It is your continuing duty to update the Board on any changes once the application has been submitted.

1. ☐ Yes ☐ No 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 or educational program, including but not limited to medical school, prior to completing the training?

2. ☐ Yes ☐ No Have you ever had any application for any professional license refused or denied by any licensing authority?

3. ☐ Yes ☐ No Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?

4. ☐ Yes ☐ No Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

5. ☐ Yes ☐ No Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

6. ☐ Yes ☐ No 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?

7. ☐ Yes ☐ No Have you ever voluntarily surrendered any professional license?

8. ☐ Yes ☐ No Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation, or had any other disciplinary action taken against any professional license you have held?

9. ☐ Yes ☐ No Have you ever been notified or requested to appear before a licensing or disciplinary agency?

10. ☐ Yes ☐ No To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?
11. □ Yes □ No Has any professional association imposed any disciplinary action against you?

12. □ Yes □ No Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?

13. □ Yes □ No Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?

14. □ Yes □ No Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?

15. □ Yes □ No Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?

16. □ Yes □ No Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?

17. □ Yes □ No Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?

18. □ Yes □ No Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?

19. □ Yes □ No Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?

20. □ Yes □ No Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUL, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

21. □ Yes □ No Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

22. □ Yes □ No Have you ever been court-martialed or discharged dishonorably from the armed services?

23. □ Yes □ No 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?

24. □ Yes □ No Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?

25. □ Yes □ No Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company?
Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): ___________________________ Date of Birth: ______________

This is to certify that I have known Dr. ___________________________ (type or print) for _____ years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. ___________________________

is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: ___________________________
Street 1: ___________________________
Street 2: ___________________________
State/Zip: ___________________________
Telephone: ___________________________
Signature: ___________________________
Date: ___________________________
ADDENDUM 3

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): ___________________________ Date of Birth: __________

Please mail this document to the Kansas State Board of Healing Arts at the address above.
Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. ___________________________ (type or print) for ____ years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. ___________________________

is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: ___________________________
Street 1: ___________________________
Street 2: ___________________________
State/Zip: ___________________________
Telephone: ___________________________
Signature: ___________________________
Date: ___________________________
ADDENDUM 4
KANSAS STATE BOARD OF HEALING ARTS

Applicant: Complete this form and email it to boardinquiry@fsmb.org. You must also check the box below.

☐ I hereby certify that I am the individual referenced below and I acknowledge that I have answered all questions and reported all information on this page truthfully and completely.

Federation of State Medical Boards of the United States, Inc.
400 Fuller Wiser Road, Suite 300 | Euless, TX 76039
Tel (817) 868-4000 Fax (817) 868-4099

Physician Data Center Inquiry Form

Attention: State Board Inquiries

The Kansas State Board of Healing Arts is requesting a PDC Search concerning the following individual:

Last Name ____________________________________________
First Name ____________________________________________
Middle Name __________________________________________
Date of Birth __________________________________________
Daytime Phone _________________________________________
Email ________________________________________________
Degree (MD, DO, or PA only) ______________________________
Medical School _________________________________________
Year of Graduation _____________________________________
Last Four Digits of Social Security Number_____________________
ECFMG # (if applicable) _________________________________
NPI Number ___________________________________________

Please mail the result to the following address:

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612
ADDENDUM 5

Kansas

INSTRUCTIONS FOR REQUESTING A CRIMINAL BACKGROUND CHECK

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.

Following is the Waiver Agreement and Statement. Please complete, sign and date the Waiver Agreement and Statement form with your application. Your application will not be deemed as complete without a completed and signed Waiver Agreement and Statement form.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. Your local law enforcement agency should be willing to assist you with completing the fingerprints. Some enforcement agencies offer electronic scanning (Livescan). Please visit our website at www.ksbha.org for a listing of Livescan agencies. Have at least one form of picture identification for the law enforcement agency to examine.

If you do not utilize a Livescan agency, contact the Board at 785-296-7413 or 888-886-7205 to receive a fingerprint card, or visit http://www.fbi.gov/about-us/cjis/identity-history-summary-checks/fd-258-1 to print a fingerprint card. If printing the card, please print on card stock paper.

Please complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submitting the fingerprint card. Be sure to include name (including aliases, maiden and previous names), 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. Sign the card in front of the law enforcement officer. If you use Livescan, the agency may have a different form for you to complete.

Make a check or money order (do not send cash) payable to the Kansas State Board of Healing Arts for $48. A fingerprint card submitted without payment will not be processed.

Provide the law enforcement officer with a stamped envelope addressed to: KSBHA, 800 SW Jackson, LL- Suite A, Topeka, KS 66612 to mail your fingerprint card or electronic scan, and fee. In addition, you may want to use a mailing service that allows for delivery confirmation to confirm your fingerprint card and payment have been received at the Board. Bent and folded cards will not be accepted and a new fingerprint card will be mailed to you for prints to be taken again.

A background check is valid for six (6) months. Application for licensure completed after the six (6) month period will be required to submit a new fingerprint card for a new clearance.

Any and all resubmissions of fingerprint cards require a $48 submission fee to process. Resubmitted fingerprint cards will not be processed without payment.

Please complete, sign and date the Waiver Agreement and Statement form with your application. Your application will not be deemed as complete without a completed and signed Waiver Agreement and Statement form.

revised 2-12-15, kl

800 SW Jackson, Lower Level, Suite A, TOPEKA, KS 66612

Kansas State Board of Healing Arts
Last revised May 2016

Uniform Application Addendum 5
Instructions
ADDENDUM 5

Kansas

WAIVER AGREEMENT AND STATEMENT
Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize 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. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, the Kansas State Board of Healing Arts may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the Kansas State Board of Healing Arts of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Kansas State Board of Healing Arts may choose to deny my application or grant me a limited or restricted license until the criminal history background check is completed.

I understand that, upon my request, the Kansas State Board of Healing Arts will provide me with a summary of the information contained in my Criminal History Background Report for the limited purpose of challenging the accuracy and/or completeness of the information contained in the report, but will not provide me with a complete copy of the Criminal History Background Report. I understand that I may obtain a prompt determination as to the validity of my challenge before the Kansas State Board of Healing Arts makes a final decision about my application for license to practice the healing arts. I further understand that I will not be provided access to information in my Criminal History Background Report under the following circumstances: 1) I am granted a full, unrestricted license, 2) I voluntarily withdraw an application for licensure, or 3) I am denied a license and have exhausted all my right to appeal the denial.

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 the provisions of Title 21 Kansas Statutes Annotated, Section 3805, and may result in the denial of my application pursuant to K.S.A. 65-2836 (a).

____________________________________________________________________________________

__________________________________________  __________________________________
Signature  Date

__________________________________________  __________________________________
Printed Name  Date of Birth

___________________________________________________________
Residential Address  City    State    Zip
CREDIT CARD PAYMENT AUTHORIZATION FORM

Please print or type.

**CARD NUMBER**

Verification Code
3-dig non-embossed number found on the card signature panel

Expiration Date

MO YR

Name (as it appears on the credit card):

Billing Address:

Street
City
State Zip

Telephone Number: __________ - __________ - __________

Payment Amount $__________ Purpose of Payment: ___________

(e.g. renewal, application)

I agree to pay the above amount per the card issuer agreement.

____________________
Signature

____________________
Date

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

office use only

Revised 12-18-07 kl
Affidavit and Authorization for Release of Information

Complete this application as directed in the left sidebar and mail to:

Kansas State Board of Healing Arts
800 SW Jackson LL, Suite A
Topeka, KS 66612

Applicant:

Sign this form with attached photo in the presence of a notary public. Send this notarized form with any other required materials to the Board at the address listed above.

If you are using FCVS for credentials verification, you must also send the separate FCVS affidavit form to FCVS if you have not already done so.

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 Uniform Application for Physician State 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 such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (less than 6 month old) front-view 2” x 2” passport-type color photo of yourself in this square.

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

Applicant’s printed last name

Applicant’s printed first name, middle initial, 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: ____________________________

Kansas State Board of Healing Arts
May 2016

UA Affidavit & Authorization for Release of Information
Licensure Verification Form

Applicant: Complete section 1 of this form as directed in the left sidebar.

Licensing Board: Complete section 2 of this form as directed in the left sidebar.
Send the completed form to the Board listed in section 1.

### Section 1: Applicant Information

| Last name: ______________________________ | Suffix: _______ | Degree Type: [ ] MD [ ] DO |
| First name: ______________________________ | Middle name: _____________________________ |
| 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.

**Authorization:** I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state, territory, or Canadian province in which I hold or have held a license, whether now current or not. I authorize the licensing agency of the state/province of __________________ to provide any and all information pertaining to license number ______________ to the following Board:

| Board name: Kansas State Board of Healing Arts |
| Mailing address: 800 SW Jackson, LL – Suite A |
| City/State/Zip: Topeka, KS 66612 |
| Applicant signature: ___________________________ Date: ______________ |

### Section 2: Licensure Verification

| Name of Licensee: __________________________ | Last | First | Middle | Suffix |
| Issuing State Board: _________________________ | License type: _________________________ |
| License number: _____________________________ | Issue date: ___________ Expiration date: ___________ |
| Is this license current? [ ] Yes [ ] No [ ] Cannot answer under state law |

1. Have formal disciplinary proceedings been initiated against this applicant’s license by a disciplinary authority in your state? [ ] Yes [ ] No [ ] Cannot answer under state law

   If yes, please explain: ____________________________

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant’s license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? [ ] Yes [ ] No [ ] Cannot answer under state law

   If yes, please explain: ____________________________

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: ______________ |
| Email: ___________________________ |

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