EFFECTIVE AS A FINAL ORDER

DATE: 6.1.22

FILED
MAY 11 2022
KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of **Samuel G. Gatz, D.C** **Kansas License No. 01-05837**	**Docket No. 22-HA00039**

SUMMARY ORDER

NOW ON THIS 11th day of May 2022, This matter comes before Susan B. Gile, Acting Executive Director, Kansas State Board of Healing Arts ("Board"), in summary proceedings pursuant to K.S.A. 77-537.

Pursuant to K.S.A. 77-537 and K.S.A. 77-542, this Summary Order shall become effective as a Final Order, without further notice, if no written request for a hearing is made within fifteen (15) days of service. Upon review of the agency record and being duly advised in the premises, the following finding of fact, conclusions of law, and order are made by and on behalf of the Board:

Findings of Fact

1. Samuel G. Gatz, D.C. ("Applicant") was first issued License No. 01-05837 to practice chiropractic in Kansas on March 13, 2017.

2. Applicant's last mailing address known to the Board is: CONFIDENTIAL

CONFIDENTIAL

3. On February 1, 2022, Applicant's license was cancelled for failure to renew.

4. Applicant applied to reinstate his active chiropractic license on February 10, 2022.

5. On March 8, 2022, Applicant emailed the Board Licensing department stating, "I have continued practicing since my license has expired. I know this I should not have, but in staying 100% truthfully I have." (Bd. Ex 1 - Application p. 5).

6. Applicant practiced chiropractic without a license for at least one month between February 2022 and March 2022.

7. Furthermore, Applicant was aware his actions were in violation of the Kansas Healing Arts Act. Application affirmatively communicated to the Board his intentions to continue actively practicing chiropractic in Kansas without an active license. While Applicant practiced during this time, he was not excluded from the Kansas Healing Arts Act under any exceptions.

Applicable Law

8. The Board has jurisdiction over Applicant as well as the subject matter of this proceeding, and such proceeding is held in the public interest.

9. Under the Kansas Healing Arts Act K.S.A. 65-2801 *et seq.*, "it shall be unlawful for any person who does not have a license to engage in the practice of any profession regulated by the board." Persons deemed engaged in the practice of chiropractic are defined under K.S.A. 65-2871. [emphasis added]

10. K.S.A. 65-2836 of the Kansas Healing Arts Act states in pertinent part:

> A licensee's license may be revoked, suspended or limited, or the licensee may be publicly censured or placed under probationary conditions, or an application for a license or for reinstatement of a license may be denied upon a finding of the existence of any of the following grounds:
>
> (b) licensee has committed an act of unprofessional conduct.
>
> (g) The licensee has unlawfully invaded the field of practice of any branch of the healing arts in which the licensee is not licensed to practice.

11. K.S.A. 65-2837(b)(12) defines "unprofessional conduct" in pertinent part to include "committing conduct likely to deceive, defraud, or harm the public."

Conclusions of Law

12. The Board finds Applicant knowingly violated K.S.A. 65-2836(g) of the Kansas Healing Arts Act by engaging in the practice of chiropractic in Kansas, as defined by K.S.A. 65-2871, without a license for a period of at least one month.

13. The Board finds Applicant also violated K.S.A. 65-2836(b) of the Kansas Healing Arts Act, as defined by K.S.A. 65-2837(b)(12), by committing conduct likely to deceive, defraud, or harm the public in that Applicant committed an act of unprofessional conduct by knowingly practicing as a chiropractor in Kansas without a license for a period of at least one month.

14. Based on the facts and circumstances set forth herein, the use of summary proceedings in this matter is appropriate, in accordance with provisions set forth in K.S.A. 77-537(a) in that the use of summary proceedings does not violate any provision of law and the protection of the public interest does not require the Board to give notice and an opportunity to participate to person other than Applicant.

IT IS ORDERED that Applicant is hereby **PUBLICLY CENSURED** and that Applicant is assessed a **CIVIL FINE** in the amount of one thousand dollars **($1,000.00)** for violations of the Kansas Healing Arts Act, due within thirty (30) days after this Order becomes a Final Order. Such fine shall be paid to the "Kansas State Board of Healing Arts," in full. All monetary payments, which shall be in the form of check or money order, relating to this Summary Order shall be mailed to the Board, certified, and addressed to:

Kansas State Board of Healing Arts
Attn: Compliance Coordinator
800 SW Jackson, Lower Level-Suit A,
Topeka, Kansas 66612.
KSBHA_ComplianceCoordinator@ks.gov

IT IS FURTHER ORDERED that, upon satisfaction of the requirements imposed by this Summary Order, Applicant's application for the reinstatement of his Active license to practice as a chiropractor in Kansas shall be granted.

PLEASE TAKE NOTICE that upon becoming effective as a Final Order, this document shall be deemed a public record and be reported to any reporting entities authorized to receive such disclosure.

Dated this 11th day of May, 2022.

KANSAS STATE BOARD OF HEALING ARTS

Susan Gile

Susan B. Gile,
Acting Executive Director

FINAL ORDER NOTICE OF RIGHTS

PLEASE TAKE NOTICE that this is a Final Order. A Final Order is effective upon service. A party to an agency proceeding may seek judicial review of a Final Order by filing a petition in the District Court as authorized by K.S.A. 77-601, *et seq*. Reconsideration of a Final Order is not a prerequisite to judicial review. A petition for judicial review is not timely unless filed within 30 days following service of the Final Order. A copy of any petition for judicial review must be served upon Susan Gile, Acting Executive Director, Kansas Board of Healing Arts, 800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612.

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the above and foregoing **FINAL ORDER** by depositing the same in the United States Mail, postage prepaid, on this 1st day of June 2022, addressed and emailed to:

Samuel G. Gatz, D.C.
CONFIDENTIAL

Applicant

And a copy was hand-delivered to:

Matthew Gaus, Associate Litigation Counsel
James McSweyn, Associate Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612
Matthew.gaus@ks.gov
James.McSweyn@ks.gov

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

Office of the General Counsel
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

And the original was filed with the office of the Executive Director.

Staff Signature

EXHIBIT 1

Application for Reinstatement

Kansas

EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406[i], 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.

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: CONFIDENTIAL _____

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: _____

Kansas

* **"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.

[i] 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).

Kans

RECEIVED
By KSBHA at 12:30 pm, Feb 10, 2022

CHIROPRACTIC REINSTATEMENT APPLICATION

Completion of this application form is necessary for consideration for licensure. Disclosure of this information is voluntary; however, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for licensure or renewal have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application may be subject to the public information laws of this state.

Please type or print. When space provided is insufficient, attach additional pages. You may reproduce these blank forms as needed. Please make sufficient copies of all forms before you begin.

License No.: 01-05837

1. Indicate your full legal name. If your name is different from that shown on your documentation, you must submit a copy of the legal document of name change.

Full Name: Samuel (first) Gary (middle) Gatz (last) _____ (suffix)

Other names used, including maiden name: _____

2. Include residence, mailing and e-mail address. Residence address may *not* be a Post Office Box, except qualified participants under the Safe At Home Act, K.S.A.75-451 *et seq.* may use substitute residential and mailing addresses.

Residence Addres CONFIDENTIAL

Mailing Address: CONFIDENTIAL
public information — street — city — county — state — zip

E-mail: _____

3. Daytime phone number (include area code) CONFIDENTIAL

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

Date of Birth: CONFIDENTIAL Place of Birth: Newton (city) KS (state/jurisdiction) USA (country) Sex: M ☑ F ☐

Social Security/Tax ID. No.: CONFIDENTIAL NPI (National Provider Identifier): 1851832562 NPI Not Applicable: ☐

5. Are you a U.S. Citizen? ☑ Y ☐ N If you answered NO, are you (check one):

A qualified alien (as defined in 8 U.S.C.A. § 1641). ☐

A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 *et seq*). ☐

An alien who is paroled into the United States under 8 U.S.C.A. § 1182(d)(5) for less than one year. ☐

A foreign national, not physically present in the United States. ☐

Other: _____

003

6. License Designation. Please select the license designation you are requesting.

Active ☑ A license issued to a person authorizing the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Applicants for active licensure must provide evidence of professional liability insurance (which will be in effect as of the date of licensure) in compliance with Kansas law before a license will be issued. Each active license may be renewed annually. Licensees must maintain and submit evidence of satisfactory completion of a program of continuing education. Licensees must maintain and submit evidence of professional liability insurance, and contribute to the Kansas Health Care Stabilization Fund (more information about this fund can be found here: https://hcsf.kansas.gov/).

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. I acknowledge by marking the exempt check box, that with an exempt license I will not be a health care provider as defined by K.S.A. 40-3401, that I am not required to maintain professional liability insurance in accordance with K.S.A. 40-3401 and that services I render while a holder of an exempt license will not be insured or covered by the Health Care Stabilization Fund. I intend to engage in the following professional activities in Kansas:_____

7. PROFESSIONAL LIABILITY INSURANCE & KHCSF COMPLIANCE (Active License Only)

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

8. List ALL employment/professional activity since your Kansas license was cancelled. Attach an additional sheet if necessary. Include actual work address, not corporate headquarters address.

Employer: Newton Chiropractic Clinic — Job description/Title: Chiropractor

Address: 515 Washington Rd (street) Newton (city) KS (state) — Dates: From 05/2018 To Present

Employer: — Job description/Title:

Address: (street) (city) (state) — Dates: From To

Employer: — Job description/Title:

Address: (street) (city) (state) — Dates: From To

Employer: — Job description/Title:

Address: (street) (city) (state) — Dates: From To

Applicant Name: _____ (please print or type)

From: sam gatz
To: Erickson, Deborah [KSBHA]
Subject: Re: Information Needed After Final Review
Date: Tuesday, March 8, 2022 11:36:26 AM
Attachments: image001.png

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

CONFIDENTIAL

On Tue, Mar 8, 2022 at 9:52 AM Erickson, Deborah [KSBHA] <Deborah.Erickson@ks.gov> wrote:

CONFIDENTIAL

Sincerely,

Deborah Erickson

Licensing Analyst

Kansas State Board of Healing Arts

800 SW Jackson, LL – Suite A

Topeka, Kansas 66612

Email: deborah.erickson@ks.gov

Phone 785.296.1386

Fax 785.296.0852

http://www.ksbha.org/main.shtml

9. List all states or jurisdictions in which you are currently or have been licensed, registered or certified in any health care profession. Attach an additional sheet if necessary. You must complete the attached *Licensure Verification* form and forward to all Boards or similar entities in which you have held any health care license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

I have never been licensed, registered or certified in another state or jurisdiction. ☑

State/Jurisdiction	License, Registrant, Certificate no.	Status	Issue Date

10. Continuing Education.

Provide proof during the 18-month period immediately preceding this application, completion of at least 50 credits of continuing education, of which at least 20 credits shall be in category I and the remaining credits in category II.

Application fee of $400, criminal background report fee of $47, and NPDB report fee of $3. If your previous Kansas license was revoked a fee of $1000 is required. Make the fee payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

Kansas

RECEIVED
FEB 18 2022

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 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 Chiropractic 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 chiropractic 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 chiropractic.

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

Samuel Gatz

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

Date of signature (must correspond to date of notarization)

Seal Verified KSBHA

NOTARY

REAGAN SPROW
Notary Public - State of Kansas
My Appt. Expires 3/18/23

State of Kansas, County of Harvey.

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 14th day of Feb, 2022

Notary Public Signature Reagan Sprow My Notary Commission Expires 3/18/2023

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

RECEIVED
By KSBHA at 9:25 am, Mar 29, 2022

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this notarized form to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to:

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

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 contained in this application 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.

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

Gate
Applicant's printed last name

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

3-21-22
Date of signature (must correspond to date of notarization)

fold up — fold up

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of Kansas, County of Harvey,

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 21st day of March, 2022.

Notary Public Signature: Reagan Sprow

My Notary Commission Expires: 3/18/23

(NOTARY PUBLIC SEAL)
REAGAN SPROW
Notary Public - State of Kansas
My Appt. Expires 3/18/23

Kansas

RECEIVED
FEB 16 2022

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 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 Chiropractic 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 chiropractic 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 chiropractic.

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

Samuel Gatz

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

Date of signature (must correspond to date of notarization) Seal Verified KSBHA

NOTARY

REAGAN SPROW
Notary Public - State of Kansas
My Appt. Expires 3/18/23

State of Kansas, County of Harvey.

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 14th day of Feb, 2022

Notary Public Signature Reagan Sprow My Notary Commission Expires 3/18/2023

Kansas State Board of Healing Arts
800 SW Jackson - Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email:

4/6/2021

Kansas

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.

Samuel Gatz
Full Name of Applicant

2/2/22
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 prior to completing the training? Yes ☐ No ☑

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

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

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4. 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. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

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

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

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

10. 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? Yes ☐ No ☑

Kansas

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

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12. Do you have any physical or mental health condition (including alcohol or substance use) that currently impairs your ability to practice your profession in a competent, ethical, and professional manner?

13. 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? Yes ☐ No ☑

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

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

CONFIDENTIAL

16. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, 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.

17. 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.

18. Have you ever been court martialed or discharged dishonorably 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 provider 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 Medicaid or Federal Medicaid 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.

Attestation Questions

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Continuing Education

In Person		
-CCSP Emergency Procedures in Sports	2/6/21 and 2/7/21	12.5hrs
Online Seminar		
-SFMA Level 1	11/21/20	7hrs
-SFMA Level 2	11/22/20	7hrs
Self Study		
-CCSP Lecture study through DC Online Website	1/1/21 to 4/1/21	100hrs
-Craig Liebenson's book "Rehabilitation of the Spine"		

Continuing Education

In Person		
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WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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.

CONFIDENTIAL

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

CONFIDENTIAL

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 5903.

The name, address, and date of birth provided below appear on a valid identification document as defined in Title 28 United States Code, section 1028.

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

Signature: [signature] Date: 2-11-22

Samuel Gatz — Date of Birth: CONFIDENTIAL

Printed Name

CONFIDENTIAL

Residential Address | City | State | Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

Method of Verifying Identity: Driver's License X | State Issued ID Card | Military ID Card

State/Branch: KS ID Number: CONFIDENTIAL

Agency Name: Harvey County Sheriffs Office

Address: 120 E 7th Office 901 Newton, KS 67114

Telephone: 316-284-6959 Fax: 316-284-6993

Name of Individual Verifying Identity: Cpl. Cale M Lasiter #1110

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

CONFIDENTIAL

Federation of Chiropractic Licensing Boards
DATABANK ACTION REPORT
CHIROPRACTIC REGULATORY BOARD ACTIONS
QUERY REPORT: CIN-BAD

Questions? Janelle Grier, CIN-BAD Administrator (970) 356-3500 / FAX / E-mail jgrier@fclb.org

Search Criteria

Last Name: Gatz
First Name: Samuel
Alias:

SUBJECT NAME **Samuel Gary Gatz** **Date of Birth** No Information Reported

Other names used

Deceased N
Gender Unknown
U.S. NPI # 1851832562

Categories Doctor of Chiropractic

CONTACT INFORMATION:

Address 1: CONFIDENTIAL

EDUCATION INFORMATION:

No education information reported

LICENSURE INFORMATION:

No license information reported

Certifications:

No certification information reported

PRIMARY SOURCE VERIFIED DATA FOLLOWS

BOARD ACTIONS:

No board actions reported

MEDICARE SANCTIONS:

No Medicare actions reported

Please note that not being listed in the database does not guarantee that actions have not been taken by regulatory boards. Reports can be in process and not yet received by the FCLB. It is strongly urged that you contact the board(s) to verify: (1) if the doctor has a license in good standing; (2) has any pending or previous actions; (3) has any complaints filed against him/her. It is the responsibility of the person initiating the search to query at a later date to see if new actions have been reported after the date of the search. This Chiropractic Information Network-Board Action Databank (CIN-BAD) is a "red-flag" service designed to bring attention to matters of potential concern or positive status. Any subsequent actions taken as a result of this report must be based on complete information obtained directly from the licensing authority(ies) which took the original board action(s), or other authorities as noted in this report. It is understood that CIN-BAD is compiled from information provided by sources including international state and provincial licensing authorities, US Department of Health and Human Services (DHHS), and others. The FCLB is not responsible for any inaccurate or incomplete information provided to it by these sources.

CERTIFICATE OF INSURANCE

BOUM
Treated Fairly

Certificate Holder:

Samuel G Gatz, DC
CONFIDENTIAL

AUTHORIZED REPRESENTATIVE

THIS CERTIFICATE ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY BELOW.

ISSUE DATE: **01/28/2022**

INSURED: **Samuel G Gatz, DC**
CONFIDENTIAL

COMPANY AFFORDING COVERAGE: **PACO Assurance Company, Inc.**
3000 Meridian Boulevard
Suite 400
Franklin, TN 37067

THIS IS TO CERTIFY THAT THE POLICY OF INSURANCE LISTED BELOW HAS BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED:

TYPE OF INSURANCE: **Professional Liability - Individual**

DESCRIPTION OF OPERATIONS: **The Named Insured practices as a Chiropractor**

POLICY NUMBER: CONFIDENTIAL

EFFECTIVE DATE: **01/07/2022** RETROACTIVE DATE: **01/07/2022**

EXPIRATION DATE: **01/07/2023**

CLAIMS-MADE LIMITS: **$500,000 / $1,500,000** **Chiropractor**

Kansas Health Care Stabilization Fund Excess Limits $500,000/$1,500,000

PG-DC-3010 Ed. 5-11

CONFIDENTIAL

OFFICIAL RECEIPT
KANSAS BOARD OF HEALING ARTS
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612
(785) 296-7413

RECEIPT NUMBER: 687634

DATE: 02/10/2022

NAME:	LICENSE TYPE:	FEE:	LIC #:
SAMUEL GATZ		REIN $400 KBI $47 NPDB $3	2.10.2022

AMOUNT: 450.00

RECEIVED FROM:

Samuel Gary Gatz
Samuel Gary Gatz
Samuel Gary Gatz

CONFIDENTIAL

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

Kansas
State Board of Healing Arts

PHONE: 785-296-7413
FAX: 785-368-7103
KSBHA_healingarts@ks.gov
www.ksbha.org

February 11, 2022

Samuel Gary Gatz, DC
CONFIDENTIAL

Dear Samuel Gary Gatz:

CONFIDENTIAL

Sincerely,
Deborah Erickson
Licensing Analyst Phone: 785-296-1386 Email: Deborah.Erickson@ks.gov

Kansas

FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS

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

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

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

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

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

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

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

Fingerprint results are valid for 6 months from the date received. Applications for licensure completed after the 6-month period will be required to submit a new Waiver Agreement, fingerprint card, and $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 Childcare Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law 103-209 and Public Law 105-251. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, 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 to challenge 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 (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of 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 USC 552a), the requesting agency 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 asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other
information that may be pertinent to the application. During the processing of this application, and for as
long hereafter as may be relevant to the activity for which this application is being submitted, the FBI
may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System

(Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

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

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness.

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 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:

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

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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.

CONFIDENTIAL

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

CONFIDENTIAL

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 5903.

The name, address, and date of birth provided below appear on a valid identification document as defined in Title 28 United States Code, section 1028.

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

Signature

Date CONFIDENTIAL

Samuel Gatz

Printed Name

Date of Birth

CONFIDENTIAL

Residential Address City State Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

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

State/Branch: _____ ID Number: _____

Agency Name: _____

Address: _____

Telephone: _____ Fax: _____

Name of Individual Verifying Identity: _____

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

Kansas

LICENSE VERIFICATION FORM

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

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

Full Name: _____

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

License or Registration No.: _____ Issue Date: _____

Profession: _____

Signature: _____ Date: _____

Full Name of Licensee or Registrant: _____

License or Registration No.: _____ Status: _____

Issue Date: _____ Expiration Date: _____

License Method: _____ School: _____

DISCIPLINARY ACTIONS:

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

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

Comments: _____

Signature: _____ (SEAL)

Title: _____

State Board of: _____

Date: _____

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

Kansas

THIRD PARTY RELEASE

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

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

1. Name: _____
   Phone: _____
   Email: _____
   Relationship: _____

2. Name: _____
   Phone: _____
   Email: _____
   Relationship: _____

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

_____ _____

Signature of Applicant Date

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

Kansas

GENERAL INFORMATION AND INSTRUCTIONS FOR REINSTATEMENT

For all information governing Chiropractic Medicine in Kansas, please visit the Statute and Regulation Handbook.

Thank you for your interest in becoming licensed in Kansas. Please read the following information very carefully. This information is vital to the successful completion of your application. Often your questions are covered in this form. 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 be licensed.

It is highly recommended you make and keep copies, for your records, of all items submitted for review. In addition, when mailing you may want to request a delivery confirmation to confirm your application has been received at the Kansas State Board of Healing Arts (KSBHA). Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to KSBHA. Do not fax original forms or documentation to the Board.

One of the missions of KSBHA is public protection through effective licensure and enforcement. One way the public is safeguarded is by issuing licenses to fully qualified, competent and ethical applicants. You will be asked a series of attestation questions. A "yes" answer is not an automatic disqualification from licensure. All applicants are considered on an individual basis. You may be requested to submit additional information or documents to the requirements mentioned herein before the application will be deemed complete to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. Failure to fully disclose could constitute grounds alone for denial of your application. Please avoid some of the common excuses: "My attorney told me I don't have to disclose." or "I did not think the prior act had anything to do with my profession or that it was still on my record or that it happened so long ago." There is no excuse for not disclosing.

Application fees must be submitted with the application. These *fees are* ***non-refundable*** and will be processed upon receipt. The Kansas reinstatement application fee for DCs is **$400**. Also, a background check fee of $47 and a National Practitioner Data Bank ("NPDB") report fee of $3 must accompany the application. This totals **$450**. 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 the KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card.

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 in 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. Failure to provide complete information will result in delay of processing the application.

You can request verification of many state licenses through Veridoc at www.veridoc.org or call 701-319-6500

The National Practitioner Data Bank (NPDB)Report was mandated by Congress and tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. All applicants include a $3 report fee for the Board to obtain the NPDB report.

DC licenses expire on January 31 and are renewed annually. Renewal will be required of all applicants receiving permanent licenses prior to November 1.

CHECK LIST: Did you complete the following?

Complete application with all questions answered.
Documentation for any "YES" Attestation Questions
Notarize and sign Affidavit and Authorization
Submit proof of completion of continuing education, if applicable
Completed Background Check Waiver, Fingerprint card, **$47 Fee.**
Request verification(s) of all licenses, permits or certifications, if applicable
Complete and sign Third Party Release, if applicable
Documentation of name change, if applicable
Proof of professional liability insurance or intent to cover
Fees

From:	sam gatz
To:	KSBHA_Licensing
Subject:	Samuel Gatz D.C. License Reinstatement
Date:	Thursday, February 10, 2022 9:27:18 AM
Attachments:	dc_reinstate_app_fillableFINISHHED.pdf Attestation Questions 2022.doc Continuing Education 2020 to...doc

CONFIDENTIAL

Kansas

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION

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

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

I acknowledge that I have read and understand the application for Chiropractic 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 chiropractic 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 chiropractic.

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 _____

Attestation Questions

CONFIDENTIAL

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