EMERGENCY TEMPORARY LICENSE APPLICATION: COVID 19 PANDEMIC

The Emergency Temporary License for the COVID-19 response is available for all health care professions regulated by the Kansas State Board of Healing Arts (Board). Those who hold an emergency temporary license are limited to engaging in the practice of their profession for healthcare services relating to COVID-19 response efforts and/or mitigating any effect of COVID-19. The license will cancel in 90 days, if not renewed, and will automatically cancel January 26, 2021. Email completed form to KSBHA_Licensing@ks.gov.

PROFESSION

In the dropdown select the profession you intend to practice.

REQUIREMENTS

Select all that apply.

Currently hold a valid federally active license.	
Currently hold a valid, full, active and unencumbered license in another state to engage in the same profession and are not the subject of any professional discipline or investigation in another state.	
Have held an active or exempt license in Kansas within the past 2 years, and such license was not suspended or revoked as a result of Board investigation or discipline.	
Meet all requirements for licensure in Kansas (or reinstatement of licensure within 5 years of lapsed license) but are currently unable to pay the fee due to effects of the pandemic.	
Meet all requirements for licensure in Kansas except licensing examination due to the exam being cancelled as a result of the pandemic and there is no temporary license/permit available under the relevant Kansas practice act.	

FULL LEGAL NAME/IDENTIFICATION

Provide your full legal name.

First Name:	Middle Name:	Last Name:	Suffix:
List all other names used, including maiden name:			
Social Security Number:		Date of Birth:	
Place of Birth:			Male____ Female____

ADDRESSES

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

Home Address	Street & Number:		
	City:	State:	Zip:
	Phone:	Email:	
Practice Address	Street & Number:		
	City:	State:	Zip:
	Phone:	Email:	
Preferred Mailing Address: (must select one)	Home Address____	Practice Address____	
Preferred Email Address: (must select one)	Home Email____	Practice Email____	

LEGAL AUTHORITY TO WORK IN THE U.S.

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

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

NPI Number:	I do not currently have an NPI number_____

POSTSECONDARY EDUCATION

Institution Name:	Degree:	Graduation Date:

OTHER LICENSES/PERMITS/CERTIFICATIONS
List all state or jurisdictions in which you currently have an active healthcare related license, permit or certification, permanent or temporary.

State	Type of License	License Number	Issue Date MM/DD/YYYY	Expiration Date MM/DD/YYYY

ATTESTATION QUESTIONS
Please answer each of the following questions. All "yes" answers MUST be thoroughly explained in detail on a separate, signed page.

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

NOTICE OF PROFESSIONAL LIABILITY INSURANCE AND KANSAS HEALTH CARE STABILIZATION FUND COMPLIANCE REQUIREMENTS

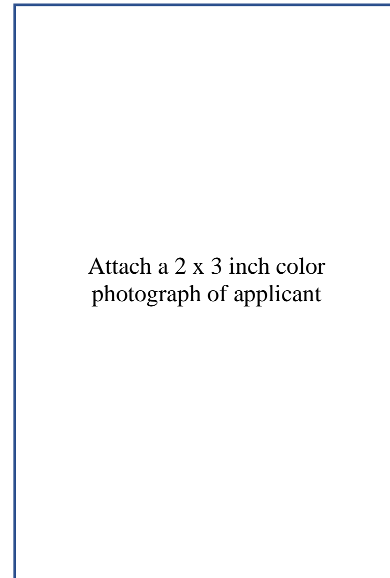
K.S.A. 40-3402 requires MD, DO, DC, DPM and PAs practicing in Kansas to maintain professional liability insurance of not less than $200,000 per claim, and not less than $600,000 annual aggregate for all claims made during the policy period. These professions are also required to maintain compliance with the Kansas Health Care Stabilization Fund (KHCSF). K.S.A. 40-3404; K.S.A. 65-2809(c). For questions relating to how to comply with Fund requirements, please contact (785) 291-3777 or email HCSF@ks.gov.

I am not an MD, DO, DC, DPM or PA. _____

I verify that I have read and understand the professional liability insurance and HCSF requirements and/or will contact the Kansas Health Care Stabilization Fund to endure compliance while I am practicing in Kansas. _____

APPLICANT PHOTO

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



Briefly describe the COVID-19 preparation, response, or mitigation efforts in which you will be engaged, including the identity of an employer/contractor contact or a current Kansas health care practitioner who can confirm your practice plans.

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

OATH

In the presence of a notary public, sign and date.

I, __________________________, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents. 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 my profession in Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years of each violation (K.S.A. 21-3805).

____ ____________________

Signature (must be signed in the presence of a notary) Date

State of__________________________________

County of________________________________ (SEAL)

Subscribed and sworn to before me this _____ day of _______________, 20_____.

____ ____________________

Notary Public Signature Commission Expires

In addition to the application, if you are an Athletic Trainer, you must submit a completed Athletic Trainer Practice Protocol.

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