GENERAL INFORMATION – CORPORATE PRACTICE OF MEDICINE (CPM)

Thank you for the interest in becoming certified in Kansas. Please read the following information carefully. This information is vital to the successful completion of the application. Often, questions you may have are covered.

The application and all forms are fillable PDF's and can be submitted electronically by emailing KSBHA_Licensing@ks.gov. If a seal or notary is required, it must be clearly visible to be accepted by email. It is highly recommended to make and keep copies of all the items submitted for the application. **Pages 1-3 of the application will not be accepted handwritten.**

Applications are processed in order of date received. Please allow **at least 2 to 4 weeks** for the processing of the application. After an application is processed a missing requirement letter ("MRL") is sent to the preferred email address. Board staff will make every effort to process the application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of the application. For updates, login to the online portal using the registration code listed in the MRL. When a certificate is issued, a notification with the wallet card is sent to the preferred email address.

Fees:

Application**: $1,000**

ALL FEES ARE NON-REFUNDABLE

CPM Application Requirements Check List:

	Complete application, with all questions answered.
	Copy of the business city/county license, if applicable.
	Documentation for any "YES" answers on the attestation questions.
	Notarize and sign copy of the Oath.
	Complete and sign Third Party Release, if applicable.

APPLICATION INSTRUCTIONS – CORPORATE PRACTICE OF MEDICINE (CPM)

Application Fees: Application fees must be submitted with the application. These *fees are* ***non-refundable*** and will be processed upon receipt. The Kansas CPM application fee is **$1, 000**. 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.

Business Entity Name: Provide the full legal business name. List all other names used, including trade names.

Addresses: The business address may **not** be a Post Office Box. The business address is public and will be posted on the Board's website. The Board will send correspondence to the business address and email, unless a mailing address is provided. If the address or contact information changes, the Board must be notified within 30 days.

Business Worksite: List the address of each worksite where professional services will be provided. Attach additional page if necessary.

City/County Occupational License: Provide the city/county occupational license information, if applicable**.** Include a copy of the current license.

Business Entity Type: Read each description and select the appropriate designation. K.S.A. 65-28,134(f)

Responsible Officials: If the business entity is organized as a governmental unit list all responsible officials. Attach additional page if necessary.

Officers/Owners/Partners: List all officers, owners, and partners. If the business entity is organized as a limited partnership or a limited liability company, provide the percentage of liability of all partners and owners. Attach additional page if necessary.

Physicians and Chiropractors to be Hired: List the name and full Kansas license number of all physicians and chiropractors to be hired. All physicians and chiropractors to be hired must have an Active Kansas license. Attach additional page if necessary. **During the initial certification process and after certification, the business entity must notify the Board of all physicians and chiropractors to be hired.**

Attestation Questions: The mission of the Board is to protect the public, which it does so in part, through effective licensure and enforcement. The public is safeguarded by issuing licenses to qualified, competent, and ethical applicants. A "yes" answer to an attestation question is not an automatic disqualification for certification – each applicant is considered on an individual basis. It is the business entity's continued duty to update the Board on any changes once the application has been submitted. Please keep in mind, **failure to fully disclose may constitute grounds for denial of your application**.

Oath: Requires the signature of an authorized officer of a corporation, authorized person of a limited liability company or limited liability partnership, or a partner of a general partnership. In the presence of a notary public, sign and date this form.

Third Party Release: Complete this form to allow Board staff to talk with third parties about the application.

CORPORATE PRACTICE OF MEDICINCE
INITIAL CERTIFICATE OF AUTHORIZATION APPLICATION

Completed application and forms can be emailed to KSBHA_Licensing@ks.gov or mailed to the Kansas State Board of Healing Arts. **Pages 1-3 of the application will not be accepted handwritten.**

BUSINESS ENTITY NAME

Provide the legal business name. List all other names used, including trade names.

Business Name:
Other Names Used:

BUSINESS ADDRESS

The business address may not be a Post Office Box. The business address is public and will be posted on the Board's website. The Board will send correspondence to the business address and email, unless a mailing address is provided.

Street & Number:	City:	State:	Zip:
Business Phone:	Business Email Address:		

MAILING ADDRESS (If different than above)

Street & Number:	City:	State:	Zip:
Phone:	Email Address:		

BUSINESS WORKSITE

List the address of each worksite where professional services will be provided. Attach additional page if necessary.

Street & Number:	City:	State:	Zip:
Street & Number:	City:	State:	Zip:
Street & Number:	City:	State:	Zip:
Street & Number:	City:	State:	Zip:
Street & Number:	City:	State:	Zip:
Street & Number:	City:	State:	Zip:

CITY/COUNTY OCCUPATIONAL LICENSE

Provide the city/county occupational license information, if applicable. Include a copy of the current license.

License Type:	License number:	Licensing Agency or Entity:

BUSINESS ENTITY TYPE

Read each description and select the appropriate designation.

Business ☐	An employer located in Kansas that utilizes electronic medical records and offers medicine and surgery or chiropractic services solely for its employees and the dependents of such employees at the employer's work site.
Insurance Company ☐	An organization that is licensed to sell accident and sickness insurance in the state that is also a mutual or non-profit health carrier that utilizes electronic medical records, or a wholly owned subsidiary of such organization that provides medical services solely for the organization's enrollees and dependents of such enrollees.
IT Company ☐	An information technology company that designs, utilizes and provides electronic medical records for businesses and worksite medical clinics for employers located in Kansas and offers medicine and surgery or chiropractic services solely to its employees and the dependents of such employees at the employer's work sites in Kansas.

RESPONSIBLE OFFICIALS (For Governmental Units only)

List all responsible officials. Attach additional page if necessary.

First Name:	Middle Name:	Last Name:	Suffix:
First Name:	Middle Name:	Last Name:	Suffix:
First Name:	Middle Name:	Last Name:	Suffix:

OFFICERS/OWNERS/PARTNERS

List all officers, owners, and partners. If the business entity is organized as a limited partnership or a limited liability company, provide the percentage of liability of all partners and owners. Attach additional page if necessary.

First Name:		Middle Name:	Last Name:	Suffix:
Officer: ☐	Owner: ☐	Partner: ☐	Percentage of Liability (if applicable): _____	

First Name:		Middle Name:	Last Name:	Suffix:
Officer: ☐	Owner: ☐	Partner: ☐	Percentage of Liability (if applicable): _____	

First Name:		Middle Name:	Last Name:	Suffix:
Officer: ☐	Owner: ☐	Partner: ☐	Percentage of Liability (if applicable): _____	

First Name:		Middle Name:	Last Name:	Suffix:
Officer: ☐	Owner: ☐	Partner: ☐	Percentage of Liability (if applicable): _____	

PHYSICIANS AND CHIROPRACTORS TO BE HIRED

List the name and full Kansas license number of all physicians and chiropractors to be hired. All physicians and chiropractors to be hired must have an Active Kansas license. Please note, in Kansas, if you have an Active license, you are required 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 and required to maintain compliance with the HCSF (the HCSF provides supplemental professional liability coverage for health care providers affected by the Fund law). *See* K.S.A. 40-3402; K.S.A. 40-3404; K.S.A. 65-2809(c). Attach additional page if necessary. **During the initial certification process and after certification, the business entity must notify the Board of all physicians and chiropractors to be hired.**

Kansas License Number:	Licensee Name:	Select
Kansas License Number:	Licensee Name:	Select
Kansas License Number:	Licensee Name:	Select
Kansas License Number:	Licensee Name:	Select
Kansas License Number:	Licensee Name:	Select
Kansas License Number:	Licensee Name:	Select

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.

1. Has the business entity ever committed fraud or misrepresentation in applying for or securing an original, renewal or reinstated certificate? Yes No
2. Has the business entity ever willfully or repeatedly violated the Kansas healing arts act, the pharmacy act of the state of Kansas or the uniform controlled substances act or any rules and regulations adopted pursuant thereto, or any rules and regulations of the secretary of health and environment that are relevant to the practice of the healing arts? Yes No
3. Has the business entity ever had a certificate, or equivalent authorization, to employ licensees to practice the healing arts revoked, suspended or limited, been censured or had other disciplinary action taken or had an application for a certificate or license denied, by the proper licensing authority of another state? Yes No
4. Has the business entity ever violated any lawful rule and regulation promulgated by the Kansas State Board of Healing Arts? Yes No
5. Has the business entity ever failed to report or reveal the knowledge required to be reported or revealed under K.S.A. 65-28,122, and amendments thereto? Yes No
6. Has the business entity ever failed to report to the Kansas State Board of Healing Arts any adverse action taken against the business entity by another state or licensing jurisdiction, a governmental agency, by a law enforcement agency or a court for acts or conduct similar to acts or conduct that would constitute grounds for disciplinary action under K.S.A. 65-28,134? Yes No
7. Has the business entity ever engaged in conduct likely to deceive, defraud or harm the public? Yes No
8. Has the business entity ever engaged in conduct that violates patient trust and exploits the licensee-patient relationship for corporate gain? Yes No
9. Has the business entity ever used any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts, including the intentional falsifying or fraudulent altering of a patient healthcare record? Yes No
10. Has the business entity ever failed to furnish to the Kansas State Board of Healing Arts ("Board"), or its investigators or representatives, any information legally requested by the Board? Yes No
11. Has the business entity ever had, or failed to report to the Kansas State Board of Healing Arts, any adverse judgment, award or settlement against the business entity resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for disciplinary action under K.S.A. 65-28,134? Yes No
12. Has the business entity ever been convicted of a felony or class A misdemeanor, or substantially similar offense in another jurisdiction, related to the practice of the healing arts? Yes No

OATH

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

Requires the signature of an authorized officer of a corporation, authorized person of a limited liability company or limited liability partnership, or a partner of a general partnership.

I, the undersigned, being duly sworn, declare under penalty of perjury under the laws of the state of Kansas that the foregoing application for the business entity listed below is true and correct.

I acknowledge that the business entity listed below shall not in any manner, directly or indirectly, interfere with, diminish, restrict, substitute its judgement for or otherwise exercise control over the independent professional judgment and decisions of its employed licensees as it relates to the care of patients; or prohibit or restrict any employed licensee from discussing with or disclosing to any patient or other individual any medically appropriate healthcare information that such licensee deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made by the business entity to approve or deny healthcare services, the availability of alternate therapies, consultations or tests, or from advocating on behalf of the patient.

_____
Business Entity Name

_____ _____
Name (printed) Title

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

State of _____ (SEAL)

County of _____

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

_____ _____
Notary Public Signature Commission Expires

THIRD PARTY RELEASE

Complete this form to allow the Kansas State Board of Healing Arts ("Board") staff to talk with third parties about the application. This form provides authorization for the Board to release information regarding the 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. This authorization may be revoked at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to receipt of the written request. A reproduction of this authorization shall have the same effect as the original. Email to KSBHA_Licensing@ks.gov or mail directly to the Board.

I, the undersigned, authorize Board staff to release and discuss any and all information pertaining to the application for the business entity listed below, with the following individuals:

1. Name: _____
   Phone: _____
   Email: _____
   Title: _____

2. Name: _____
   Phone: _____
   Email: _____
   Title: _____

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.

_____
Business Entity Name

_____ _____
Name (printed) Title

_____ _____
Signature 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

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Please enter required information, sign and date at the bottom. Email or Mail form.

☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS ☐ MasterCard

CARD NUMBER

Verification Code
3-4-digit 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)

Applicant/Licensee Name:_____

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			

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Revised 9/4/19