

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Submit the completed form to the Board. Payments are processed in order of date received.

Expiration Date: (MM/YY) Purpose of Payment: (Application, NPDB, KBI, Verification of License Fee, etc.) To view license Fee List, click here. Name of Cardholder: City: Phone: Email: APPLICANT/LICENSEE INFORMATION: Name of Applicant/Licensee: Discense Number: By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge above-mentioned amount. I understand that failure to submit the required information will delay process of the payment. Cardholder Signature Date	Card Type:	DISCOVER NETWOOD	AMERICAN EXTRESS	faster Card		
Purpose of Payment: (Application, NPDB, KBI, Verification of License Fee, etc.) To view license Fee List, click here. Name of Cardholder: Street Address: City: Phone: Email: APPLICANT/LICENSEE INFORMATION: Name of Applicant/Licensee: License Number: By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge above-mentioned amount. I understand that failure to submit the required information will delay process of the payment.	Card Number:					
Name of Cardholder: Street Address: State: Zip:	Expiration Date: (N	MM/YY)	Verification	on Code:		
Street Address: State: Zip:	Purpose of Paymen (Application, NPDB, KBI,	t: Verification of License	Fee, etc.) To view licens	e Fee List, click h	Amount:	
Mailing Address City: Phone: Email: APPLICANT/LICENSEE INFORMATION: Name of Applicant/Licensee: License Number: By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge bove-mentioned amount. I understand that failure to submit the required information will delay proces of the payment.						
Phone: Email: APPLICANT/LICENSEE INFORMATION: Name of Applicant/Licensee: License Number: By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge bove-mentioned amount. I understand that failure to submit the required information will delay proces of the payment.		Street Address:				
APPLICANT/LICENSEE INFORMATION: Name of Applicant/Licensee: By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge bove-mentioned amount. I understand that failure to submit the required information will delay process of the payment.	Mailing Address	City:			State:	Zip:
Name of Applicant/Licensee: By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge above-mentioned amount. I understand that failure to submit the required information will delay process of the payment.		Phone:		Email:		
Name of Applicant/Licensee: By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge bove-mentioned amount. I understand that failure to submit the required information will delay proces of the payment.	APPLICANT/LIC	ENSEE INFOR	MATION:			
By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge bove-mentioned amount. I understand that failure to submit the required information will delay proces of the payment.				License Number		
Cardholder Signature Date	Name of Applicant	/Licensee:		e Kansas Sta		
	Name of Applicants By signing below, I bove-mentioned am	/Licensee:	permission to the		te Board of Hea	ling Arts to charge
	Name of Applicants By signing below, I bove-mentioned amount of the payment.	/Licensee:	permission to the		te Board of Hea uired informatio	ling Arts to charge

Records Act.