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APPLICATION PACKET REQUEST

Please enter all applicable information. E-mail, fax or mail your request. Some applications are available for download from www.ksbha.org.

Please indicate which profession application packet you are requesting

☐ Athletic Trainer ☐ Chiropractic ☐ Medicine & Surgery ☐ Naturopathic Doctor
☐ Occupational Therapist ☐ Occupational Therapist Asst. ☐ Osteopathic Medicine & Surgery
☐ Physical Therapist ☐ Physical Therapist Asst. ☐ Physician Assistant ☐ Podiatry
☐ Radiologic Technologist ☐ Respiratory Therapist ☐ Respiratory Therapist - Student

Full Name: _____

Mailing Address: _____
Street

_____
City State Zip

Daytime Telephone Number (including area code): _____

E-Mail Address: _____

_____ _____
Medical/Professional School City State Country Date or Expected date of Graduation

Have you ever been licensed in Kansas? ☐ Yes ☐ No
If YES, please provide your license number. _____

List ALL states you have ever been granted a license/registration.

_____

Submitting FCVS ☐ Yes ☐ No USMLE Step 3 Exam Request ☐ Yes ☐ No
ECFMG Certificate no. if applicable: _____

Examination(s) completed or expected to complete:

☐ Comlex I ☐ Comlex II ☐ Comlex III
☐ National Boards I ☐ National Boards II ☐ National Boards III ☐ National Boards IV
☐ USMLE I ☐ USMLE II ☐ USMLE III
☐ FLEX I ☐ FLEX II ☐ NPLEX I ☐ NPLEX II
☐ STATE EXAM (LIST STATE) _____ ☐ PMLEXIS
☐ ARRT ☐ NATABOC ☐ NBCOT ☐ NBRC
☐ NPTE ☐ NCCPA ☐ NMTCB

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