KANSAS STATE BOARD OF HEALING ARTS
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612
(785) 296-7413 or
Toll Free (888) 886-7205
(785) 368-7103 (FAX)
www.ksbha.org

DISCIPLINARY PROCEDURE

The Kansas State Board of Healing Arts ("Board") is comprised of 15 members appointed by the Governor, 12 licensees, and 3 members from the general public. The Board licenses or registers 13 health care professions and out-of-state contact lens distributors. The mission of the Board is to protect the public by requiring those professionals to meet and maintain certain qualifications and standards of conduct.

WHOM DOES THE BOARD REGULATE?

- Medical Doctors (M.D.)
- Osteopathic Doctors (D.O.)
- Chiropractic Doctors (D.C.)
- Podiatric Doctors (D.P.M.)
- Naturopathic Doctors (N.D.)
- Physician's Assistants (P.A.)
- Physical Therapists (P.T.)
- Physical Therapist Assistants (P.T.A.)
- Occupational Therapists (O.T.)
- Occupational Therapy Assistants (O.T.A.)
- Respiratory Therapists (R.T.)
- Athletic Trainers (A.T.)
- Radiologic Technologists (L.R.T.)
- Contact Lens Distributors

The Board does NOT have disciplinary jurisdiction over any other healthcare professions, hospitals, or other healthcare facilities. Please see last page for other regulatory agencies.

When a complaint is received by Board staff an initial determination is made: the complaint must pertain to the practice of a profession licensed by the Board, and must allege facts constituting a violation of the laws administered by the Board. These two requirements are necessary to open a case for investigation. If the complaint contains insufficient information, more information may be requested from the complainant.

EXAMPLES OF PROHIBITED CONDUCT

- Commissions of acts of gross negligence or multiple acts of ordinary negligence;
- Conviction of a felony or Class A misdemeanor;
- Fraudulent or false advertising;
- Fraudulent billing;
- Prescribing or distributing drugs for other than lawful purposes;
- The inability to practice the healing arts with reasonable skill and safety to patients by reason of illness, alcoholism, excessive use of drugs, or any mental or physical condition;
- Sexual abuse, misconduct or exploitation related to the person's practice;
- Referring a patient to a health care entity for services, if the licensee/registrant has a significant investment interest in the entity, (10% ownership or more) unless the person regulated by the Board informs the patient of the interest in writing, and that patient may obtain such services elsewhere;
- Other acts as proscribed by law.

Once a case is opened, it is assigned to an investigator. The investigation usually involves obtaining medical records from the licensee/registrant and any necessary health care facility. It may also involve interviewing witnesses, visiting facilities, obtaining drug profiles and getting information from law enforcement or other regulatory agencies, in this state or elsewhere. Board investigations are time consuming and may take several months, depending on the seriousness and complexity of the allegations.

Board investigations are required by law to be confidential, pursuant to K.S.A. 65-2898a. Therefore, there are limits to what information may be released, even to the person making the complaint. The Board has broad authority to obtain information even though the information may otherwise be confidential as a privileged communication. However, other information may be available only with the patient's specific consent.

Once a complaint is investigated, it undergoes a review process. If the issue involves competency, the case may be reviewed by a panel of peers to determine whether the standard of care was met.

If the issue involves unprofessional conduct (sexual misconduct, false advertising, etc.), the case is reviewed by a staff attorney to determine whether there is sufficient evidence of a violation of the statutes and regulations. If there is evidence of a violation, the case is reviewed by a panel of the Board to determine what action, if any, to take. At that time, a petition may be filed against the licensee/registrant. The purpose of the petition is to seek public disciplinary action against the licensee/registrant.

The petition may be heard by a Hearing Officer who will provide an initial determination to the Board about the case. The licensee/registrant or the Board's attorney may then ask the Board to review the case. Either before or after the hearing, the attorneys representing the Board and the licensee/registrant may negotiate an agreement to resolve the case, for submission to the Board for approval.

The Board has the legal authority to revoke, suspend, or limit licenses/registrations, impose fines, reprimand, require monitoring or additional education, or other remedial measures. **The Board does not represent individuals, nor obtain compensation or monetary damages on behalf of individuals. Each person is free to seek legal representation if they believe it is necessary. Board investigations and reviews are not subject to discovery by private litigants.**

If you believe you have been damaged or lost money due to a licensed or unlicensed individual, you are free to contact your personal attorney regarding recovery options.

If you have any questions regarding the functions of the Board, please call (785) 296-7413.

OTHER STATE REGULATORY AGENCIES/BOARDS

Kansas State Board of Nursing
Landon State Office Building
900 SW Jackson, Room 1051
Topeka, KS 66612
(785) 296-4929 www.ksbn.org

Kansas Department for Aging and Disability Services
KDADS Complaint Program
New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404
(800) 842-0078 http://www.kdads.ks.gov/

Behavioral Sciences Regulatory Board
712 S. Kansas Ave
Topeka, KS 66603
(785) 296-3240 www.ksbsrb.org

KS Dept of Health & Environment Bureau of Health Facilities
Curtis State Office Building
1000 SW Jackson, Suite 200
Topeka, KS 66612
(800) 842-0078 www.kdheks.gov/bhfr

Kansas Optometric Association
1266 SW Topeka Blvd
Topeka, KS 66612
(785) 232-0225 www.kansasoptometric.org

Kansas State Board of Pharmacy
800 SW Jackson, Suite 1414
Topeka, KS 66612
(785) 296-4056 www.kansas.gov/pharmacy

Kansas State Board of Mortuary Arts
700 SW Jackson, Suite 904
Topeka, KS 66603
(785) 296-3980 www.kansas.gov/ksbma

Kansas Insurance Department
420 SW 9th
Topeka, KS 66612
(785) 296-3071 www.ksinsurance.org

Kansas Dental Board
Landon State Office Building
900 SW Jackson, Room 564-S
Topeka, KS 66612
(785) 296-6400 www.kansas.gov/kdb

Kansas Attorney General
Memorial Hall
120 SW 10th 2nd Floor
Topeka, KS 66612
(785) 296-2215 (Main) www.ksag.org
(785) 296-3751 (Consumer Protection Division)
(785) 296-2359 (Crime Victims Compensation Board)

Kansas Board of Cosmetology
714 SW Jackson, Suite 100
Topeka, KS 66603
(785) 296-3155 www.accesskansas.org

KANSAS STATE BOARD OF HEALING ARTS
ATTN: COMPLAINT COORDINATOR
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612
(785) 296-7413 or
Toll Free (888) 886-7205
(785) 368-7103 (FAX)

COMPLAINT FORM

PLEASE NOTE:

Your complaint is very important to the Kansas State Board of Healing Arts ("Board") as it is critical in assisting us protect the public and informs us of any possible violations.

The Board will not perform investigations to benefit a personal litigation case or act as your attorney. The Board does not obtain monetary compensation on behalf of an individual or engage in dispute resolution. If you believe you have been damaged or lost money due to a licensed or unlicensed individual, you are free to contact your personal attorney regarding recovery options.

Board investigations and reviews are not subject to discovery by private litigants. Only public action will be disclosed to the complainant and/or the public.

We only have authority over the individuals we license:

M.D. (Medical Doctor)	P.A. (Physician Assistant)	O.T.A. (Occupational Therapist Assistant)
D.O. (Osteopathic Doctor)	P.T. (Physical Therapist)	R.T. (Respiratory Therapist)
D.C. (Chiropractor)	P.T.A. (Physical Therapy Assistant)	A.T. (Athletic Trainer)
D.P.M. (Podiatrist)	L.R.T. (Radiologic Technologists)	Contact Lens Distributors
N.D. (Naturopathic Doctor)	O.T. (Occupational Therapist)	

INSTRUCTIONS: (Please type or print legibly.)

Please furnish all identifying information for the complainant, patient and all practitioners and facilities involved in the complaint. When providing any address, list the street address, not a post office box. Please complete all pages of this form. Additional pages may be added if necessary.

PRACTITIONER(S) AGAINST WHOM ALLEGATION IS MADE: (Please include the first name, last name, and appropriate title (as listed above):

NAME: _____

ADDRESS: _____

_____

PHONE: (_____) _____

NAME: _____

ADDRESS: _____

_____

PHONE: (_____) _____

PERSON MAKING COMPLAINT: (Please notify this agency if the following information changes.)

NAME: _____
First Middle Last Other Names Used

ADDRESS: _____
Street

_____
City State Zip Code

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____

May we contact you at your place of employment? YES _____ NO _____ (Agency working hours are 8:00 a.m. to 4:30 p.m.)

Best time to contact you would be? _____a.m./p.m. to _____ a.m./p.m.

PATIENT INFORMATION:

NAME: _____
First Middle Last Other Names Used

ADDRESS: _____
Street

_____
City State Zip Code

DATE OF BIRTH: _____ SSN: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____

FACILITIES INVOLVED IN THE INCIDENT: (Hospitals, Nursing Homes, Clinics, Etc.)

FACILITY: _____ **FACILITY**: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

PHONE: (_____) _____ PHONE: (_____) _____

FACILITY: _____ **FACILITY**: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

PHONE: (_____) _____ PHONE: (_____) _____

WITNESS(ES) TO THE INCIDENT: (If known.)

NAME: _____

ADDRESS: _____

_____

PHONE: (_____) _____
Home and W

NAME: _____

ADDRESS: _____

_____

PHONE: (_____) _____
Home and Work

NAME: _____

ADDRESS: _____

_____

PHONE: (_____) _____
Home and Work

NAME: _____

ADDRESS: _____

_____

PHONE: (_____) _____
Home and Work

PLEASE LIST A FRIEND OR RELATIVE WHO WILL KNOW YOUR MOST CURRENT ADDRESS AND PHONE NUMBER.

NAME: _____

ADDRESS: _____

PHONE: (_____) _____
Home and Work

PHONE: (_____) _____

NARRATIVE

Please describe in detail all allegations against the practitioner(s). Describe each incident with specific dates and list any witnesses. Attach copies of any documents you have concerning the allegations. **Use additional sheets if necessary.**

DATE OF INCIDENT: _____ PATIENT'S NAME: _____

YOUR RELATIONSHIP TO PATIENT, IF OTHER THAN YOURSELF: _____

I acknowledge that the Kansas State Board of Healing Arts may provide a copy of this form to the person against whom the allegations are made.

I agree to testify in any hearings which may arise as a result of these allegations. The statements I have made are true and correct to the best of my knowledge and belief.

DATE: _____ SIGNED: _____

GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization authorized to provide the information:

   _____

   _____

   _____

   _____

2. The Kansas State Board of Healing Arts, ("Board") its representatives, agents or employees are specifically authorized to receive and use my health information. Please send information to:

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

3. I specifically authorize the release of all my health information in your possession or control including medical records of every kind, billing information, films, monitoring strips, and any record requested by the Board.

4. The purpose of this request is to permit the Board access to all of my health information necessary in furtherance of health oversight activities.

5. I understand I have the right to revoke this authorization at any time by notifying the Board in writing at 800 SW Jackson, Lower Level-Suite A, Topeka, Kansas 66612. I understand that the revocation is only effective after it is received by the Board.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it to other health oversight agencies and law enforcement entities as permitted by state and federal law.

7. I understand that if I do not sign this authorization, the Board may not be able to fully investigate my complaint. I also understand that in furtherance of health oversight activities, the Board possesses subpoena power that permits them to command the disclosure of my health information from certain individuals and entities without my permission. This authorization is intended to permit individuals and entities not subject to the Board's subpoena power to provide copies of my health information to the Board.

8. I understand that I am entitled to receive a copy of this authorization.

9. I understand that this authorization will expire upon completion of the Board's investigation into the matter(s) about which I am complaining, or upon the completion of any legal proceedings that might arise out of my complaint, whichever event is latest.

_____ _____
Signature of Patient Date

OR:

_____ _____
Signature of Personal Representative Date
(signature warrants he/she has authority to sign as Personal Representative)

_____
Patient's Date of Birth

Revised August 6, 2013