APPLICATION FOR THE PRACTICE OF CHIROPRACTIC

Completion of this application form is necessary for consideration for licensure. Disclosure of this information is voluntary; however, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for licensure or renewal have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application may be subject to the public information laws of this state.

Please type or print. When space provided is insufficient, attach additional pages. You may reproduce these blank forms as needed. Please make sufficient copies of all forms before you begin.

1. Indicate your full legal name. If your name is different from that shown on your documentation, you must submit a copy of the legal document of name change.

Full Name: _____
first middle last suffix

Other names used, including maiden name: _____

2. Include residence, mailing and e-mail address. Residence address may *not* be a Post Office Box, except qualified participants under the Safe At Home Act, K.S.A.75-451 *et seq.* may use substitute residential and mailing addresses.

Residence Address: _____
street city county state zip

Mailing Address: _____
public information street city county state zip

E-mail: _____

3. Daytime phone number (include area code): _____

4. Identification. Disclosure of your social security number is required by federal mandates set forth in 42 U.S.C.S. § 666(a)(13). K.S.A. 74-148(a) provides that every application by an individual for a professional license shall require the applicant's social security number. K.S.A. 74-139 requires disclosure of your social security number upon request to the Kansas director of taxation. Your social security number may be provided for child support enforcement actions, to the Kansas director of taxation, for reporting disciplinary actions to the National Practitioner Data Bank-Health Integrity and Protection Data Bank (NPDB-HIPDB) as required by 45 C.F.R. §§ 61.1 *et seq.* Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Such disclosure is for identification purposes only. Your social security number will not be released for any other purpose not permitted by law.

Date of Birth: _____ Place of Birth: _____
city state/jurisdiction country

Sex: M ☐ F ☐

Social Security/Tax ID. No: _____ NPI (National Provider Identifier): _____ NPI Not Applicable: ☐

Are you a U.S. Citizen? Y ☐ N ☐ 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 United States. ☐

Other: _____

5. In chronological order, list all post-secondary schools you have attended, even those from which you did not graduate. Attach an additional page if necessary. Applicants who matriculated in chiropractic college on or after January 1, 2000 must present proof of a baccalaureate degree from an accredited school. If the bachelor's degree is granted by a chiropractic school, at least 90 semester hours applicable to the bachelor's degree shall be earned at an accredited school, with none of these hours applying to the Doctor of Chiropractic degree. Request official transcript(s) with final degrees awarded be mailed or sent electronically from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors

School Name:

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Degree: _____
month year month year

School Name: _____

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Degree: _____
month year month year

6. List all Preceptorships. Attach an additional sheet if necessary.

I have not participated in a preceptorship. ☐

Field Doctor: _____

Address: _____ Dates: From _____ To _____
street city state

7. National Board of Chiropractic Examiners exams. **Contact NBCE to provide proof of examination scores.**

Part 1: Date _____ Passed Part 2: Date _____ Passed

Part 3: Date _____ Passed Part 4: Date _____ Passed

8. List all employment/professional activity since graduation. Attach an additional sheet if necessary.
Include actual work address, not corporate headquarter's address. ☐
I have not been employed or had professional activity since graduation..

Employer: _____ Job description/Title: _____

Address: _____ Dates: From _____ To _____
street city state mm/yy mm/yy

Employer: _____ Job description/Title: _____

Address: _____ Dates: From _____ To _____
street city state mm/yy mm/yy

Applicant Name: _____
(please print or type)

9. List all states or jurisdictions in which you are currently or have ever been licensed, registered or certified as a Chiropractor. Attach an additional sheet if necessary. KSBHA will verify your credentials except for any state that does not provide free and current verifications on their official state website. For those states, you may complete the attached *Licensure Verification* form and forward to all Boards or similar entities in which you have held a DC license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

I have never been licensed, registered or certified in another state or jurisdiction. ☐

State	Issue Date	License Type	License Number

10. License Designation. Please select the license designation you are requesting.

Active ☐ A license issued to a person authorizing the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Applicants for active licensure must provide evidence of professional liability insurance (which will be in effect as of the date of licensure) in compliance with Kansas law before a license will be issued. Each active license may be renewed annually. Licensees must maintain and submit evidence of satisfactory completion of a program of continuing education. Licensees must maintain and submit evidence of professional liability insurance, and contribute to the Kansas Health Care Stabilization Fund (more information about this fund can be found here: https://hcsf.kansas.gov/).

Federal Active ☐ A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

Inactive ☐ A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

Exempt ☐ A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect. I acknowledge by marking the exempt check box, that with an exempt license I will not be a health care provider as defined by K.S.A. 40-3401, that I am not required to maintain professional liability insurance in accordance with K.S.A. 40-3401 and that services I render while a holder of an exempt license will not be insured or covered by the Health Care Stabilization Fund. I intend to engage in the following professional activities in Kansas:

Application fee of $300 and NPDB report fee $3. Make the fees payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

Applicant Name: _____
(please print or type)

EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406[i], please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/ federal/military/law enforcement agencies.

1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes ☐ No ☐ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes☐ No☐ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

3. Do you currently reside in Kansas? Yes☐ No☐ If yes:

   Current Kansas Residence Address:_____

4. Do you intend* to establish residency in Kansas within the next 6 months? ***If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in KS and will be reported to all appropriate state/federal/military agencies in other jurisdictions.*** Yes ☐ No ☐ If yes:

   Intended Kansas Residence Address:_____

   Expected Date of Commencing Residence:_____

If you answered "no" to all questions #1 through #4, you do not need to answer questions #5 through #7.

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. ***This does not include certifications or registrations issued by private boards, professional societies, or any organization other than a government body of a state, district, or territory of the U.S.*** Yes ☐ No ☐If no:

   a. Have you practiced the profession for which you are seeking licensure in Kansas for at least 3 years in a state that does not license/register/certify the profession? Yes ☐ No ☐

   b. Have you practiced the profession for which you are seeking licensure in Kansas for at least 2 years in a state that does not license/register/certify the profession and you held a certification or registration issued by a private organization during those 2 years? Yes ☐ No ☐ If yes:

Organization that issued private certification/registration:_____ Date Issued:_____

*** "Active practice" does not include care provided while in a training program, residency, or fellowship; or employment that consisted solely of research activities or administrative duties. The Board generally considers active practice to be direct patient care that for either (1) at least one full day per week for 50 weeks during a year; or (2) 400 hours during a year.**

6. Have you actively practiced* the profession for which you are seeking licensure in Kansas during the last 2 years? Yes ☐ No ☐

If you answered "yes" to question #6, you do not need to answer question #7.

7. If you answered "No" to questions #6, please provide a detailed explanation regarding your active clinical practice and direct patient care during the 12 months immediately preceding the submission of your application. Please explain any gaps in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

[i] An applicant who has not been in the active practice of their occupation during the two years preceding the application for which a license is sought, may be required to complete additional testing, training, monitoring or continuing education as the KSBHA deems necessary to establish present ability to practice in a manner that protects the health and safety of the public. K.S.A. 48-3406(d).

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. All information received will be checked accordingly to verify the truth and veracity of your answers. **It is imperative you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

If you are unsure of your response to a question, check the "yes" box and submit the appropriate documentation. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty. Please be advised that a false response to any of these questions may be grounds for denial of licensure. If a question is not applicable, then check the "no" box.

Full Name of Applicant _____ Date _____

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training? Yes ☐ No ☐
2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes ☐ No ☐
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes ☐ No ☐
4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges? Yes ☐ No ☐
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility? Yes ☐ No ☐
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private? Yes ☐ No ☐
7. Have you ever voluntarily surrendered any professional license? Yes ☐ No ☐
8. 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 ☐
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes ☐ No ☐
10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes ☐ No ☐

11. Has any professional association imposed any disciplinary action against you? Yes ☐ No ☐

12. Do you have any physical or mental health condition (including alcohol or substance use) that currently impairs your ability to practice your profession in a competent, ethical, and professional manner? Yes ☐ No ☐

13. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances? Yes ☐ No ☐

14. Have you ever surrendered your state or federal controlled substances registration, or had it revoked, suspended, or restricted in any way? Yes ☐ No ☐

15. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency? Yes ☐ No ☐

16. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes ☐ No ☐

17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes ☐ No ☐

18. Have you ever been court martialed or discharged dishonorably from the armed services? Yes ☐ No ☐

19. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself? Yes ☐ No ☐

20. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company? Yes ☐ No ☐

21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company? Yes ☐ No ☐

It is your continued duty to update the Board on any changes once the application has been submitted.

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION

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

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the application for Chiropractic licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if a change occurs any time prior to a license to practice chiropractic being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license to practice chiropractic.

Applicant Photograph

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

_____

Applicant's signature (must be signed in the presence of a notary)

_____

Applicant's printed first name middle initial, last name, and suffix (e.g., Jr.)

_____

Date of signature (must correspond to date of notarization)

NOTARY

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____day of _____, 20_____

Notary Public Signature _____ My Notary Commission Expires _____

PROFESSIONAL SCHOOL VERIFICATION

Applicant complete Section 1 of this form then send to your professional school. Request the Dean or designated official to complete Section 3 and return this form, a copy of your official transcript, and a copy of your diploma directly to this Board.

Section 1: Applicant Information

Full Name: _____
first middle last suffix

Other names used, including maiden name: _____

Date of Birth: _____ Social Security/Tax ID. No: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the chiropractic school below to provide any and all information pertaining to my chiropractic education at your institution to the below listed chiropractic board.

_____ _____
signature date

Section 2: Instructions to the Dean or designated official of the school

Please complete Section 3 of this form, certify the enclosed copy of the applicant's diploma by placing your school seal on it, and enclose an official copy of the transcripts of the above named applicant and forward all documents directly to:

The Kansas State Board of Healing Arts
Attn: Licensing
800 SW Jackson, Lower Level - Suite A
Topeka, KS 66612

Section 3: School Verification

Name of School: _____

Address: _____
street city county state zip

Applicant's Attendance Dates: _____ Graduated _____ Degree: _____
mm/dd/yr mm/dd/yr

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

_____
signature

affix institutional seal here
(if no seal is available, this form must be notarized)

_____
title

_____
date

revised 1-25-11, kl

800 SW Jackson, Lower Level-Suite A., TOPEKA KS 66612
Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

KANSAS DOCTOR OF CHRIOPRACTIC JURISPRUDENCE EXAM

Name_____ Date_____

This jurisprudence exam has several sections that describe actions that are in violation of the Kansas Healing Arts Act. Any of these violations can lead to the SUSPENSION, RESTRICTION, OR REVOCATION of the Doctor's license. Write the letter of the most applicable statute in the blank next to the violation.

SECTION I

_____Licensee has another person complete this exam.

_____Licensee advertises "guaranteed results."

_____Licensee advertises "permanent cures for incurable diseases."

_____Licensee refuses to honor patient's request to send records to another licensee of the Healing Arts Board.

_____Licensee allows a person to treat and bill under his name and license.

_____Licensee lies on an application for a license.

_____Licensee tells patients licensee has board certification when he or she is not board certified.

_____Licensee's agents fraudulently solicit patients.

_____Licensee performs an inappropriate breast examination.

_____Licensee violates any Healing Arts Board lawful rule or regulation.

KANSAS STATUTES FOR SECTION I

A. K.S.A. 65-2837(b)(15) Allowing another person or organization to use the licensee's license to practice the healing arts.

B. K.S.A. 65-2837(b)(16) Commission of any act of sexual abuse, misconduct or other improper sexual contact which exploits the licensee - patient relationship, with a patient or a person responsible for the health care decisions concerning such patient.

C. K.S.A. 65-2836(k) The licensee has violated any lawful rule and regulation promulgated by the board or violated any lawful order or directive of the board previously entered by the board.

D. K.S.A. 65-2837(b)(20) Failure to transfer patient records to another licensee when requested to do so by the subject patient or by such patient's legally designated representative.

E. K.S.A. 65-2837(b)(8) Advertising to guarantee any professional service or to perform any operation painlessly.

F. K.S.A. 65-2836(n) The licensee has cheated on or attempted to subvert the validity of the examination for a license.

G. K.S.A. 65-2837(b)(12) Conduct likely to deceive, defraud or harm the public.

H. K.S.A. 65-2836(a) The licensee has committed fraud or misrepresentation in applying for or securing an original, renewal or reinstated license.

I. K.S.A. 65-2837(b)(1) Solicitation of professional patronage through the use of fraudulent or false advertisements, or profiting by the acts of those representing themselves to be agents of the licensee.

J. K.S.A. 65-2837(b)(2) Representing to a patient that a manifestly incurable disease, condition or injury can be permanently cured.

SECTION II

_____Licensee falsifies medical records to assist patient in obtaining workers' compensation benefits.

_____Licensee repeatedly practices in a manner that is below the standard of care.

_____Licensee fails to keep detailed records.

_____Licensee is convicted of a felony or class A misdemeanor.

_____Licensee becomes addicted to drugs or alcohol.

_____Licensee's license from another state is suspended or revoked.

_____Licensee initiates treatment without the patient's consent.

_____Licensee fails to report another licensed doctor who is violating provisions of the Kansas Healing Arts Act.

_____Licensee refuses to supply information to the Healing Arts Board that has been legally requested.

_____Licensee unlawfully invades the field of practice of another branch of the healing arts which the licensee is not licensed to practice.

KANSAS STATUTES FOR SECTION II

A. K.S.A. 65-2836(r) The licensee has failed to furnish the board, or its investigators or representatives, any information legally requested by the board.

B. K.S.A. 65-2836(g) The licensee has unlawfully invaded the field of practice of any branch of the healing arts in which the licensee is not licensed to practice.

C. K.S.A. 65-2836(j) The licensee has had a license to practice the healing arts revoked, suspended or limited, has been censured or has had other disciplinary action taken, or an application for a license denied, by the proper licensing authority of another state, territory, District of Columbia or other country.

D. K.S.A. 65-2836(c) The licensee has been convicted of a felony or class A misdemeanor, whether or not related to the practice of the healing arts.

E. K.S.A. 65-2836(e) The licensee is addicted to or has distributed intoxicating liquors or drugs for any other than lawful purposes.

F. K.S.A. 65-2837(b)(24) Repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances.

G. K.S.A. 65-2837(b)(3) Assisting in the care or treatment of a patient without the consent of the patient, the attending physician or the patient's legal representatives.

H. K.S.A. 65-2837(b)(25) Failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results.

I. K.S.A. 65-28,122 Any person licensed to practice the healing arts who possesses knowledge not subject to the physician-patient privilege that another person so licensed has committed any act which may be grounds for disciplinary action shall immediately report such knowledge, under oath, to the state board of healing arts.

J. K.S.A. 65-2837(b)(17) The use of any false, fraudulent or deceptive statement in any document connected with the practice of healing arts including the intentional falsifying or fraudulent altering of a patient or medical care facility record.

SECTION III

_____Licensee commits several acts of ordinary negligence.

_____Licensee brags about patient Smith's response to care without Smith's permission.

_____Licensee fails to obtain 50 required hours of continuing education.

_____Licensee allows malpractice insurance policy to lapse.

_____Licensee refers a patient to an outside health care facility that the doctor has a significant investment interest in without informing the patient in writing of that interest.

_____Licensee refers patient to another health care practitioner or facility and accepts a referral fee.

_____Licensee commits one or more acts of gross negligence.

_____Licensee advertises professional superiority.

_____Licensee makes misleading statements about his skills or treatment.

_____Licensee knowingly submits misleading or deceptive information on any insurance claim form.

KANSAS STATUTES FOR SECTION III

A. K.S.A. 65-2837(b)(29) Referring a patient to a health care entity for services if the licensee has a significant investment interest in the health care entity, unless the licensee informs the patient in writing of such significant interest and that the patient may obtain such services elsewhere.

B. K.S.A. 65-2837(b)(7) Advertising professional superiority or the performance of professional services in a superior manner.

C. K.S.A. 65-2836(aa) The licensee has knowingly submitted any misleading, deceptive, untrue or fraudulent representation on a claim form, bill or statement.

D. K.S.A. 65-2837(a)(1) One or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board.

E. K.S.A. 65-2837(b)(6) Willful betrayal of confidential information.

F. K.S.A. 65-2837(a)(2) Repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board.

G. K.S.A. 65-2836(y) The licensee has failed to maintain a policy of professional liability insurance as required by K.S.A. 40-3402 or 40-3403a and amendments hereto.

H. K.S.A. 65-2837(b)(13) Making a false or misleading statement regarding the licensee's skill or the efficacy or value of the drug, treatment or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition of the body or mind.

I. K.S.A. 65-2837(b)(19) Directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, other then through the legal functioning of lawful professional partnerships, corporations or associations.

J. K.S.A. 65-2809(b) The board shall require every licensee in the active practice of the healing arts within the state to submit evidence of satisfactory completion of a program of continuing education required by the board.

SECTION IV

_____Doctor of Chiropractic charges an excessive fee for an adjustment.

_____Doctor of Chiropractic delivers babies.

_____Doctor of Chiropractic allows employees to adjust patients.

_____Doctor of Chiropractic performs minor surgery.

_____Doctor of Chiropractic orders or dispenses Botox.

_____Doctor of Chiropractic orders additional physiotherapy treatment because the patient has insurance that will cover the cost.

_____Doctor of Chiropractic advertises free x-rays and then bills patients' insurance companies for those services.

_____Doctor of Chiropractic routinely writes off insurance deductibles and insurance co-payment amounts or charges insurance companies a higher fee than patients who do not have insurance.

_____Doctor of Chiropractic uses the letters or term "Dr." or "Doctor" with his or her name without the using the letters "D.C." or words that identify that he or she holds a chiropractic license.

KANSAS STATUTES FOR SECTION IV

A. K.S.A. 65-2885 Every such licensee when using the letters or term "Dr." or "Doctor" shall use the appropriate words or letters to identify himself with the particular branch of the healing arts in which he holds a license.

B. K.S.A. 65-2837(b)(21) Performing unnecessary tests, examinations or services which have no legitimate medical purpose.

C. K.S.A. 65-2837(b)(18) Obtaining any fee by fraud, deceit or misrepresentation.

D**.** K.S.A. 65-2837(b)(22) Charging an excessive fee for services rendered.

E. K.S.A. 65-2836(d) The licensee has used fraudulent or false advertisements.

F. K.S.A. 65-2837(b)(26) Delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience or licensure to perform them.

G. K.S.A. 65-2871 Persons deemed engaged in practice of chiropractic. For the purpose of this act the following persons shall be deemed to be engaged in the practice of chiropractic: (a) Persons who examine, analyze and diagnose the human living body, and its diseases by the use of any physical, thermal or manual method and use the X-ray diagnosis and analysis taught in any accredited chiropractic school or college and (b) persons who adjust any misplaced tissue of any kind or nature, manipulate or treat the human body by manual, mechanical, electrical or natural methods or by the use of physical means, physiotherapy (including light, heat, water or exercise), or by the use of foods, food concentrates, or food extract, or who apply first aid and hygiene, but chiropractors are expressly prohibited from prescribing or administering to any person medicine or drugs in materia medica, or from performing any surgery, as hereinabove stated, or from practicing obstetrics. **(K.S.A. 65-2871 can be used more than once in this section of the exam.)**

FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS

A criminal background check is required prior to issuance of licensure. Be aware that fingerprint processing may delay your application. **Please make it a priority to complete the fingerprint process.**

Following is the Waiver Agreement and FBI Privacy Act Statement. Please complete, sign and date the top portion of this form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Please visit https://www.nbinformation.com/locations/locationMap.php for a listing of fingerprinting locations.

Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the fingerprints must be printed on the fingerprint card and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email KSBHA_Licensing@ks.gov or call (785) 296-7413.

Complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submission. Include name, aliases, complete mailing address, social security number, citizenship, date of birth, and personal information (sex, race, height, weight, eyes, hair, place of birth). The spaces for OCA, FBI and MNU numbers can be left blank. Cards with missing or incomplete information will be rejected and must be resubmitted.

Mail the completed Waiver Agreement and fingerprint card to the Board. You may want to use a mailing service that allows for delivery confirmation.

Kansas State Board of Healing Arts
Attn: Licensing
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612
Phone: (785) 296-0934
Email: KSBHA_Licensing@ks.gov

Fingerprint results are valid for 6 months from the date received. Applications for licensure completed after the 6-month period will be required to submit a new Waiver Agreement, fingerprint card, and $47 fee.

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) **The Kansas State Board of Healing Arts** to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. The fingerprints are authorized to be submitted under the authority of the National Childcare Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law 103-209 and Public Law 105-251. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, the Authorized Recipient may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the above-referenced Authorized Recipient of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Authorized Recipient may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities until the criminal history background check is completed.

I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose to challenge the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. (See 5 United States Code (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C.534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).
Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other
information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

Routine Uses:
The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System

(Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:
The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness.

Alternatively, you may obtain a copy of your **Kansas criminal history record information** (CHRI) to review for accuracy and completeness, by submitting a set of your fingerprints, a letter requesting your criminal history record, and payment of the appropriate fee to the KBI. For further details, including the current fee, visit the following Internet website: http://www.kansas.gov/kbi/info/info_brochures.shtml then find the brochure named "Record Checks for Non-Criminal Justice Purposes". Or, to provide official court documents to make a correction you may write to:

Kansas Bureau of Investigation
Attn: Criminal History Records
1620 SW Tyler
Topeka, Kansas 66612-1837

If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license, certification or registration, or adoption.

To obtain a copy of your **national CHRI, also known as the Identity History Summary**, for review and challenge you must submit a set of your fingerprints and the appropriate fee to the FBI. Information regarding this process may be obtained at: https://www.fbi.gov/services/cjis/identity-history-summary-checks. Or, you may write to:

FBI CJIS Division
Attn: Criminal History Analysis Team 1
1000 Custer Hollow Road
Clarksburg, West Virginia 26306

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34). The Authorized Recipient must submit a new set of fingerprints and fee to receive the updated federal criminal history record.

I have ☐ ***OR*** have not ☐ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 5903.

The name, address, and date of birth provided below appear on a valid identification document as defined in Title 28 United States Code, section 1028.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information how to challenge my criminal records for accuracy and completeness.

Signature Date

Printed Name Date of Birth

Residential Address City State Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

Method of Verifying Identity: ☐ Driver's License ☐ State Issued ID Card ☐ Military ID Card

State/Branch: _____ ID Number: _____

Agency Name: _____

Address: _____

Telephone: _____ Fax: _____

Name of Individual Verifying Identity: _____

AUTHORIZED RECIPIENT: ***1. Must maintain original or arrange for KBI to maintain.***
2. Must provide a copy to the applicant.

LICENSE VERIFICATION FORM

Send to all states or jurisdictions in which you currently, or have ever, held a license, permit, or certification, permanent or temporary. Verification fees may be applicable and are the applicant's responsibility. Please contact individual boards to confirm fees. The applicant should complete the top section. The official state board should complete the bottom section and email to KSBHA_Licensing@ks.gov or mail it directly to the Kansas State Board of Healing Arts.

I, hereby authorize and request the state Board of _____ having control of any documents, records, and other information pertaining to me to furnish to the Kansas State Board of Healing Arts information including documents and/or records regarding charges or complaints filed against me or my license/registration; informal, pending, closed or any other pertinent information.

Full Name: _____

Other Names Used (if applicable): _____ Date of Birth: _____

License or Registration No.: _____ Issue Date: _____

Profession: _____

Signature: _____ Date:_____

Full Name of Licensee or Registrant: _____

License or Registration No.: _____ Status: _____

Issue Date: _____ Expiration Date: _____

License Method: _____ School: _____

DISCIPLINARY ACTIONS:

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? Yes ☐ No ☐ Unable to Divulge ☐

Have formal disciplinary proceedings been initiated against the applicant or applicant's license or registration by a disciplinary authority in your state? Yes ☐ No ☐ Unable to Divulge ☐

Comments: _____

Signature: _____ (SEAL)

Title: _____

State Board of: _____

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

THIRD PARTY RELEASE

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

I, _____, authorize Board staff to release and discuss any and all information pertaining to my application, with the following individuals:

1. Name: _____
   Phone: _____
   Email: _____
   Relationship: _____

2. Name: _____
   Phone: _____
   Email: _____
   Relationship: _____

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.

_____ _____

Signature of Applicant 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

GENERAL INFORMATION AND INSTRUCTIONS

Please visit www.ksbha.org for all statutes and regulations governing the practice of Chiropractic

Thank you for your interest in becoming licensed in Kansas. Please read the following information very carefully. This information is vital to the successful completion of your application. Often your questions are covered in this form. Please allow two (2) weeks after the submission of the application before contacting our office. **Do not** make a commitment to any work dates prior to be licensed.

Kansas does not have direct reciprocity with any state. It is highly recommended you make and keep copies, for your records, of all items submitted for review. In addition, when mailing you may want to request a delivery confirmation to confirm your application has been received at the Kansas State Board of Healing Arts (KSBHA) office. Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to the KSBHA. Do not fax original forms or documentation to the Board.

One of the missions of KSBHA is public protection through effective licensure and enforcement. One way the public is safeguarded is by issuing licenses to fully qualified, competent and ethical applicants. You will be asked a series of attestation questions. A "yes" answer is not an automatic disqualification from licensure. All applicants are considered on an individual basis. You may be requested to submit information or documents in addition to the requirements mentioned herein before the application will be deemed complete to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. Failure to fully disclose could constitute grounds alone for denial of your application. Please avoid some of the common excuses: "My attorney told me I don't have to disclose." or "I did not think the prior act had anything to do with my profession or that it was still on my record or that it happened so long ago." There is no excuse for not disclosing.

Kansas application fee: $300. Kansas application fee must be submitted with the application and is **NOT** refundable. You may pay by check, debit card, Visa, MasterCard, Discover, American Express or money order. Make checks payable to KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, debit card or credit card.

List the date passed and number of attempts you took each part of the National Board of Chiropractic Examiners (NBCE). All applicants must pass Parts I and II of the NBCE, as well as Part III if the applicant graduated after June 1988 and Part IV if the applicant graduated after April 1997. Additionally, all applicants must have passed the NBCE Physiotherapy exam with at least a 375 or the chiropractic transcript must show successful completion of Physiotherapy I and II or 120 hours of Physiotherapy. Request an official copy of your NBCE exam scores be sent directly to the Board by visiting https://nbce.learningbuilder.com/account/login.

In chronological order, list all post-secondary schools you have attended, even those from which you did not graduate. Attach an additional page if necessary. Applicants who matriculated in chiropractic college on or after January 1, 2000 must present proof of a baccalaureate degree from an accredited school. If the bachelor's degree is granted by a chiropractic school, at least 90 semester hours applicable to the bachelor's degree shall be earned at an accredited school, with none of these hours applying to the Doctor of Chiropractic degree. Request official transcript(s) with final degrees awarded be mailed or sent electronically from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors.

For all malpractice claims include a written statement from the insurance company or insurance/personal/institution attorney. Include date of occurrence, name of the insurance company involved in your behalf, name of claimant(s), other defendant(s) and/or institution involved, list of all attorneys involved, case number and location of filing, status of the matter, and summary of the occurrence. Failure to provide complete information will result in delay of processing the application.

The National Practitioner Data Bank (NPDB) Report was mandated by Congress and tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. All applicants include a $3 report fee for the Board to obtain the NPDB report.

DC licenses expire on January 31 and are renewed annually. Renewal will be required of all applicants receiving permanent licenses prior to November 1.

CHECK LIST: Did you complete the following?

Complete application with all questions answered.
Request official transcript with the final Chiropractic degree awarded directly from the professional school.
Request the professional school certification be completed by the professional school and submitted directly to the Board.
Request official transcript with the final degree awarded directly by the undergraduate school, if applicable.
Request NBCE exam scores be sent to the board.
Complete the jurisprudence Exam
Request verification of other licenses, permits or certifications, if applicable.
Documentation of professional liability insurance, if applicable.
Documentation for any "YES" answers on the attestation questions.
Documentation of name change, if applicable.
Notarize and sign the Affidavit and Authorization.
Complete Background Check Waiver and fingerprints.
Complete and sign the Third Party Release, if applicable.

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Email the completed form to KSBHA_Licensing@ks.gov or mail directly to the Board. Payments are processed in order of date received.

Name of Applicant/Licensee:		License Number:	
Purpose of Payment:		Amount:	

(Application, NPDB Fee, KBI Fee, Verification of Licensure, etc.)

Name of Cardholder:			
Billing Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	

Card Type: ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS ☐ MasterCard	
Card Number:	
Expiration Date: (MM/YY)	Verification Code:

**Do not add spaces or dashes to numbers*

By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge the above-mentioned amount. I understand that failure to submit the required information will delay processing of the payment.

Cardholder Signature _____ Date _____

Please note: The information on this form is considered personal and not subject to disclosure under the Kansas Open Records Act.

Kansas State Board of Healing Arts
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