APPLICATION FOR PODIATRY

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. List ALL podiatric schools you have attended, even those from which you did not graduate in chronological order. **Attach an additional sheet if necessary. Enclose or send an official transcript(s) from the podiatric school and a sealed or notarized copy of the diploma.**

School Name: _____

Address: _____
street city state zip country

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

6. List all Postgradate Medical Education or Preceptorships. Attach an additional sheet if necessary.

Intership ☐ Residency ☐

Name of Program: _____

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Successfully completed: Yes ☐ NO ☐
month year month year

7. National Board of Podiatric Examiners Part III (formally PMLexis) . Contact NBPME to provide proof of examination score.

Date Passed _____ Score _____

8. List ALL employment/professional activity since graduation. Account for all time and explain all gaps in professional activity. 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

9. List all states or jurisdictions in which you are currently or have ever been licensed, registered or certified as a podiatrist. 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 DPM 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/Jurisdiction	License, Registrant, Certificate no.	Status	Issue Date

Applicant Name: _____
(please print or type)

10. Please answer each of the following questions by putting a check in the appropriate box. 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 that 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 particular question, check the "yes" box and submit the appropriate form if required. 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, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check the "no" box.

(a) Yes ☐ No ☐ 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?

(b) Yes ☐ No ☐ Have you ever had any application for any professional license refused or denied by any licensing authority?

(c) Yes ☐ No ☐ Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?

(d) Yes ☐ No ☐ 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?

(e) Yes ☐ No ☐ Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

(f) Yes ☐ No ☐ 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?

(g) Yes ☐ No ☐ Have you ever voluntarily surrendered any professional license?

(h) Yes ☐ No ☐ 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?

(i) Yes ☐ No ☐ Have you ever been notified or requested to appear before a licensing or disciplinary agency?

(j) Yes ☐ No ☐ 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?

(k) Yes ☐ No ☐ Has any professional association imposed any disciplinary action against you?

(l) Yes ☐ No ☐ Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?

(m) Yes ☐ No ☐ Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?

(n) Yes ☐ No ☐ Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?

Applicant Name: _____
(please print or type)

(o) Yes ☐ No ☐ Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?

(p) Yes ☐ No ☐ Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?

(q) Yes ☐ No ☐ 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?

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

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

(t) Yes ☐ No ☐ 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.

(u) Yes ☐ No ☐ 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.

(v) Yes ☐ No ☐ Have you ever been court martialed or discharged dishonorably from the armed services?

(w) Yes ☐ No ☐ 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?

(x) Yes ☐ No ☐ Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or private insurance company?

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

Additional information, reference the question letter and include date, place, reason and disposition of the matter. Attach all relevant legal documentation.

_____

_____

_____

_____

11. Statement of Health.

Do you presently have any physical or mental problems or disabilities which could effect your ability to competently practice your particular branch of the healing arts or your particular specialty? If yes, provide a detailed statement of your health diagnosis and prognosis, supported by a report from the attending physician, including any medications and treatment currently being prescribed.

Yes ☐ No ☐

Applicant Name: _____
(please print or type)

12. Photo.

Attach a **2"x 3" wallet size** photograph of applicant with head and shoulder areas only. The photograph must have been taken within 90 days prior to date of application. Proof photographs, negatives, copies of photographs, poor quality, photographs cut from books, newspaper articles or passport photos are **NOT** accepted.

Photo here

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

Active ☐ A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

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: _____

14. Oath must be signed by applicant and notarized.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice podiatry in the state of Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years of each violation (K.S.A. 21-3805).

_____
Signature of Applicant

Sworn to before me this _____ day of

_____ 20 _____

SEAL here

_____ Notary Public

_____ Commission Expires

15. Application fee of $300. NPDB report fee $3.00. 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)

Addendum 1

Third Party Authorization

Must be signed by applicant and notarized.

I,_____ , hereby authorize all hospitals, institutions or organization, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Kansas Board of Healing Arts or its successors any information, files or records requested by the Board in connection with this application. I further authorize the Kansas State Board of Healing Arts or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure.

_____
Signature of Applicant

Sworn to before me this _____day of

_____ 20 _____

_____ Notary Public

SEAL here

_____ Commission Expires

Revised 4-13-11 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

Addendum 2

TWO PROFESSIONAL RECOMMENDATIONS

The KSBHA requires two (2) recommendations from licensed podiatrists. Persons attesting to the good character of the applicant are attesting to the fact they have known the applicant for at least one (1) year. Make copies of this form as needed.

Full Name of Applicant: _____ Date of Birth: _____
first middle last suffix

Please mail this document to:

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

DO NOT RETURN TO THE APPLICANT

This is to certify that I have known _____ for _____ year(s);
(name of applicant, please print)

that he/she is capable podiatrist and is not addicted to alcohol or narcotics. I further certify that to the best of my knowledge and belief _____ is a fit and proper person for
(name of applicant, please print)

endorsement for a license by the Kansas State Board of Healing Arts.

_____ _____
name, please print profession

_____
address

_____
city, state and zip

_____
phone number

_____
signature

_____
date

Addendum 2

TWO PROFESSIONAL RECOMMENDATIONS

The KSBHA requires two (2) recommendations from licensed podiatrists. Persons attesting to the good character of the applicant are attesting to the fact they have known the applicant for at least one (1) year. Make copies of this form as needed.

Full Name of Applicant: _____ Date of Birth: _____
first middle last suffix

Please mail this document to:

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

DO NOT RETURN TO THE APPLICANT

This is to certify that I have known _____ for _____ year(s);
(name of applicant, please print)

that he/she is capable podiatrist and is not addicted to alcohol or narcotics. I further certify that to the best of my knowledge and belief _____ is a fit and proper person for
(name of applicant, please print)

endorsement for a license by the Kansas State Board of Healing Arts.

_____ _____
name, please print profession

_____
address

_____
city, state and zip

_____
phone number

_____
signature

_____
date

CREDIT CARD PAYMENT AUTHORIZATION

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

☐ DISCOVER NETWORK ☐ MasterCard ☐ AMERICAN EXPRESS ☐ VISA

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)

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

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

STATE VERIFICATION FORM

Send to all states in which a license or registration has ever been issued. 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 return 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; formal, 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

Comments _____

(SEAL)

Signature _____

Title _____

State Board of _____

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

Addendum 5

PROFESSIONAL SCHOOL VERIFICATION

Applicant Instructions: Complete Section 1 of this form then send this form to your professional school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form and a copy of your official transcripts 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 podiatric school below to provide any and all information pertaining to my podiatric education at your institution to the below listed podiatric 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 1
Topeka, KS 66612

Section 3: School Verification

Name of School: _____

Address: _____
street city county state zip

Applicant's Attendance Dates: _____ Graduated _____ Degree: _____
month year month year

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

POSTGRADUATE TRAINING VERIFICATION

Applicant Instructions: Complete Section 1 and Section 2 of this form then send this form to your training program
Request the Program Director or designated official to complete Section 3 of this form and return 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 podiatry school below to provide any and all information pertaining to my medical education at your institution to the below listed podiatry board.

_____ _____
signature date

Section 2: Instructions to the Program Director or designated official of the postgraduate training program.

Please complete Section 3 of this form and forward directly to:

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

Section 3: Postgraduate Training Verification

Institution Name: _____

Address: _____
street city county state zip

Applicant's Attendance Dates: _____ to _____ Successfully Completed: Yes ☐ No ☐
mm/dd/yr mm/dd/yr

The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility.

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

GENERAL INFORMATION AND INSTRUCTIONS FOR PODIATRY

Please visit www.ksbha.org for all statutes and regulations governing Podiatry.

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: $300.00. Kansas application fee must be submitted with the application and is **NOT** refundable. You may pay by check, debt 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, debt card or credit card.

Visit the Federation of Podiatric Medical Boards to request test scores and Federation Report at www.fpmb.org or call 561-752-3735. Kansas requires a minimum score of 75 on the NBPME Part III (formally PMLexis) examination.

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. For all applications postdated on or after October 1, 2014 include a $3.00 report fee for the Board to obtain the NPDB report.

DPM licenses expire on September 30 and are renewed annually. Renewal will be required of all applicants receiving permanent licenses prior to July 1.

CHECK LIST: Did you complete the following?

All questions answered on the application
Provide documentation to any "Yes" answers to #10
Enclose a head and shoulder photograph (size:2x3, taken within 90 days of application) #12
Sign the Oath #13
Notarize and sign the Release addendum #1
Request two (2) professional recommendation's signatures that have known you for a minimum of one (1) year addendum #2
Request verification(s) of licenses from states, countries, or jurisdictions, if applicable, addendum #4
Complete the professional school certification & send to the school to complete addendum #5
Notarize a copy of Podiatric Diploma addendum #5
Request an official & final transcript submitted by the professional school addendum #5
Complete the postgraduate training verification and send to the postgraduate program to complete addendum #6
Request a Federation Report
Request NBPME Part III score (Formally PMLexis)
Fees

AUTHORIZATION AND RELEASE INFORMATION

Please complete if you would like for Board staff to talk with others concerning your application.

I, _____ , hereby authorize the Kansas State Board of Healing Arts ("Board")
print name

to release and discuss any and all information pertaining to my application pending before the Board with the following **TWO** individual(s):

Name of Individual	Phone Number	E-mail Address	Relationship to Individual

☐ Application Information (Initial, Reinstatements, Renewals, etc.) ☐ Payment Information ☐ License Verifications

☐ Status Changes ☐ Address Changes ☐ Healthcare Stabilization Fund Information ☐ Continuing Education Information

☐ Audit Information ☐ Former and/or Current Legal Documents ☐ Former and/or Current Legal Issues

Name of Individual	Phone Number	E-mail Address	Relationship to Individual

☐ Application Information (Initial, Reinstatements, Renewals, etc.) ☐ Payment Information ☐ License Verifications

☐ Status Changes ☐ Address Changes ☐ Healthcare Stabilization Fund Information ☐ Continuing Education Information

☐ Audit Information ☐ Former and/or Current Legal Documents ☐ Former and/or Current Legal Issues

This Authorization and Release **expires one year** from date of signature reflected on this form. Prior to expiration, this Authorization and Release may be revoked in writing at any time. A reproduction of this Authorization and Release shall have the same effect as the original.

_____
Signature

_____
Date