



**RENEWAL OF PODIATRY LICENSE**  
**OCTOBER 1, 2018 TO SEPTEMBER 30, 2019**

**ONLINE RENEWAL IS AVAILABLE** at [www.ksbha.org](http://www.ksbha.org) from August 15, 2018 to October 31, 2018.

**Do not** submit a paper renewal application if you have completed the online renewal process.

If you have questions please visit the FAQs on our website at [www.ksbha.org](http://www.ksbha.org) or call 785-296-2575.

The renewal application and fee must be received postmarked by **SEPTEMBER 30, 2018** to renew your license. A late fee must be paid for renewal applications completed on-line or received postmarked **OCTOBER 1, 2018 or later**. If an online renewal or complete renewal application is not received postmarked on or before **OCTOBER 31, 2018**. Your license will cancel on November 1, 2018 if not renewed. Any person desiring to reinstate a cancelled license must contact the Board office for the appropriate form. **A license will not be renewed if the application is not complete.** Please print or type all responses.

1. **License Number:** \_\_\_\_\_ **Current license type:** \_\_\_\_\_ 2. **Name:** \_\_\_\_\_

3. **Addresses:**  I have had a change of address since the last renewal

*Mailing Address:* \_\_\_\_\_  
 Street or PO BOX City County State Zip

*Residence Address:* \_\_\_\_\_  
 Street City County State Zip

*Telephone / Cell :* \_\_\_\_\_ / \_\_\_\_\_

*Business Address* (May **not** be a Post Office Box. Additional business addresses may be submitted on a separate page.)

\_\_\_\_\_  
 Street City County State Zip

*Telephone / Fax:* \_\_\_\_\_ / \_\_\_\_\_

*E-mail:* \_\_\_\_\_

4. **National Provider Identifier (NPI) (All License Types):** \_\_\_\_\_  n/a

5. **License Type Change (Complete only if you wish to change your License Type)** To verify your current license type review your wallet card, or visit our website [www.ksbha.org](http://www.ksbha.org) and click verification or call 785-296-2575.

I would like to change my current license type of: \_\_\_\_\_ effective \_\_\_\_\_ to:

- Active** - Submit a list of professional activities since you had an active/federal active Kansas license, proof of liability insurance certification and proof of a minimum 54 hours of CME for the last 3 years - see parts 8 and 14.
- Federal Active** - Allows a person who is active military or employed by the federal government to also engage in administrative & charitable services in Kansas, no private practice. Submit a list of professional activities since you had an active/federal active Kansas license and proof of a minimum of 54 hours of CME for the last 3 years - see part 8.
- Inactive** - Does not allow the holder to provide professional services in Kansas.
- Exempt** - Allows a person to provide some professional services - must complete part 6

6. **Professional Activities (Exempt License Type Only)** I intend to engage in the following professional activities in Kansas:

- Consultant  Charitable Health Care Provider  None
- Coroner/Deputy Coroner  Treatment of Family and Friends with No Compensation
- Administration  Other: \_\_\_\_\_

**Continue on page 2**

Office Use Only

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**7. Kansas Hospital Privileges (Active and Federal Active License Types Only)**

I do not have Kansas Hospital Privileges.

\_\_\_\_\_  
Facility Name and County

\_\_\_\_\_  
Facility Name and County

\_\_\_\_\_  
Facility Name and County

**8. Continuing Education (Active and Federal Active License Types with 2018 CME Year Only):** To verify your CME year review your wallet card, or visit [www.ksbha.org](http://www.ksbha.org) and click on verification or call 785-296-2575.

Your current CME Year is: \_\_\_\_\_

The Board will verify compliance with continuing education requirements in an undetermined percentage of renewal applications. This verification will involve an audit of records maintained by the licensee. You must maintain your continuing education records for a three year period in a manner that allows them to be readily produced. I understand the audit process and I have met the hours for the following continuing education update.

I have completed a minimum of 54 continuing education hours from 10-01-2015 through 09-30-2018

**DO NOT** mail in proof of your CME with the renewal form unless you are changing your license type to "active" or "federal active".

**9. DEA Registration number(s) (All License Types)**(use additional pages if necessary)  n/a

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**10. Dispensing Physician (Active and Federal Active License Types Only)**

The definition of a dispensing physician according to K.A.R. 100-21-1 is a person licensed to practice medicine and surgery who purchases and keeps drugs and compounds his or her own prescription for the purpose of supplying such drugs to his or her patients. Do you dispense prescription medications?  Yes  No

**11. You must answer the following questions. If you answer "yes" to any of the following questions you must provide written documentation, either by answering the questions listed on the Disciplinary form (available at [www.ksbha.org](http://www.ksbha.org)) or a detailed written response within 14 days. (All License Types)**

- (a)  Yes  No In the past 12 months have you been a defendant or have you continued to be a defendant or has any judgment, award or settlement been paid on your behalf as a result of a professional liability claim?
- (b)  Yes  No In the past 12 months have you been arrested, charged with or convicted of any felony, misdemeanor or the military equivalent? This includes a diversion or plea to a felony, misdemeanor or the military equivalent.
- (c)  Yes  No In the past 12 months has any disciplinary action been initiated or taken against you by any state or government agency, or have you been denied a license, had any adverse action taken on your license, surrendered or consented to limitation of your license to practice in any state or country?
- (d)  Yes  No In the past 12 months have any privileges related to your professional as a health care provider been suspended, restricted, limited or voluntarily surrendered or has any peer review or professional association initiated or taken any action against you?
- (e)  Yes  No In the past 12 months have you suffered from any impairment which might affect your ability to safely practice, been referred to and/or participated in a program for impaired providers?
- (f)  Yes  No In the past 12 months have you been the subject of any investigation regarding allegations, complaints or charges by any state licensing agency or other government agency?

**12. Identify all other authorities that have ever licensed you to practice podiatry (All License Types) (use additional pages if necessary):**  I have not been or currently licensed in another state or country.

State or Country:	License No.:	Date Issued:	Status:	State or Country:	License No.:	Date Issued:	Status:
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**13. Medical Malpractice Screening Panel (All License Types)**

Pursuant to K.S.A. 65-4901, the Kansas State Board of Healing Arts is required to maintain and make available a current list of health care providers who are willing and available to serve on a medical malpractice screening panel.

Are you willing to serve on a malpractice screening panel?  Yes  No

**14. Liability Insurance (Active License Type Only)** As a condition of providing professional services in Kansas, whether or not physically located in Kansas, each person with an active license must pay the annual surcharge to the Kansas Health Care Stabilization Fund (KHCSF) and either maintain a policy of professional liability insurance with a minimum of \$200,000 per claim and \$600,000 aggregate or be covered by a qualified self insurance fund. The Board will verify compliance with liability insurance requirements in an undetermined percentage of renewal applications. This verification will involve an audit of records maintained by the licensee. You must maintain your liability insurance records for a three (3) year period in a manner that allows them to be readily produced. I understand the audit process and

I maintain a policy of liability insurance that complies with Kansas statutes and have paid the annual surcharge to KHCSF.

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Insurer	Policy Number	Effective Date	Expiration Date
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I am covered by a qualified self insurance fund & have paid annual surcharges to KHCSF.

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**15. Supervision of non-licensed person(s) performing radiological technology procedures (Active, Federal Active & Exempt License Types Only)**

Do you supervise any person(s) performing radiological technology procedures who are not licensed as a radiologic technologist?  Yes  No

If you supervise a non-licensed person(s) performing radiological technology, do you certify that they have been trained on the equipment required by K.A.R. 100-73-9?  Yes  No

If you supervise a non-licensed person(s) performing radiological technology, do you certify that they have obtained or will obtain continuing education as required by K.A.R. 100-73-9?  Yes  No

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**16. Voluntary Supplemental Public Statement (All License Types)**

Pursuant to K.S.A. 65-28, 131, on and after July 1, 2010, the board shall make available on a searchable website which shall be accessible by the public, the following information regarding licensees:

- (1) The licensee's full name, business address, telephone number, license number, type, status and expiration date;
- (2) the licensee's practice specialty, if any, and board certifications, if any;
- (3) any public disciplinary action taken against the licensee by the board or by the licensing agency of any state or other country in which the licensee is currently licensed or has been licensed in the past;
- (4) any involuntary limitation, denial, revocation or suspension of the licensee's staff membership or clinical privileges at any hospital or other health care facility, and the name of the hospital or facility, the date the action was taken, a description of the action, including any terms and conditions of the action and whether the licensee has fulfilled the conditions of the action;
- (5) any involuntary surrender of the licensee's drug enforcement administration registration; and
- (6) any final criminal conviction or plea arrangement resulting from the commission or alleged commission of a felony in any state or country.

At the time of licensure or renewal, a licensee may add a statement to such licensee's profile as it appears on the website created herein for the purpose of providing further explanation of any disciplinary information contained in your profile. **Do you wish to add a statement to further explain any disciplinary information contained in your public profile.? This statement must be received by the Board within 30 days after your license expiration date.**  Yes  No

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**17. Office-Based Surgery (Active, Federal Active & Exempt License Types Only)** In Kansas, have you since your last renewal, performed any procedure in your office that requires sedation, including IV sedation of any kind: inhaled agents, parenteral, regional, spinal, epidural or general anesthesia? ("Office" as used here does not include a hospital based practiced. Also excluded are minor procedures that can be performed safely and comfortably with any one or combination of the following: a low dose oral sedative that does not affect the patient's level of consciousness; local; topical; or no anesthesia.)  Yes  No

If answered "yes", please provide accrediting entity name: \_\_\_\_\_

and certification number: \_\_\_\_\_

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Continue on page 3

**18. Expert Witness (All License Types):**

Are you willing to serve as an expert for the Board in a licensing disciplinary case?  Yes  No

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**19. Renewal Fee by Status:** Active or Federal Active: \$330.00 (\$350.00 if postmarked October 1 through October 31)  
Inactive or Exempt: \$150.00 (\$175 if postmarked October 1 through October 31)

License fees are the responsibility of the licensee. A license will not be renewed until the correct payment is received.

**20.** Pursuant to K.S.A. 65-28,131, information provided herein deemed public may be posted on our website. Failure to furnish the Board any information legally requested by the Board may be deemed as unprofessional conduct and may be the basis for disciplinary action.

By this submission I hereby certify that I am the licensee named in this renewal application and I have personally submitted all data requested in the renewal application form. I understand that Kansas Statutes allow the Board to revoke, suspend or limit a license, censure the license, or impose a fine in an amount up to \$5,000 for any act of fraud or misrepresentation in applying for renewal of a license.

I declare, under penalty of perjury under the laws of the state of Kansas that the foregoing is true and correct.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

PLEASE RETURN TO:

Kansas State Board of Healing Arts Attention: Licensing  
800 SW Jackson, LL Suite A  
Topeka, KS 66612

website: [www.ksbha.org](http://www.ksbha.org)

voice : 785 296-2575 or 888 886-7205



## CREDIT CARD PAYMENT AUTHORIZATION

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



### CARD NUMBER

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### Verification Code

3-4 digit non-embossed number found on the card signature panel

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### 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, LL Suite A., TOPEKA, KS 66612  
Voice: 785-296-7413 Toll Free: 888-886-7205 Fax: 785-296-0852 Website: [www.ksbha.org](http://www.ksbha.org)

Print Form