Print Form

APPLICATION FOR REINSTATEMENT

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.

Medicine & Surgery ☐ Osteopathic Medicine & Surgery ☐ Chiropractic ☐ Podiatry ☐

License No.: _____

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: ☐

5. 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: _____

6. 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:_____

7. Professional Liability Insurance (only for those applying for active license designation). Kansas law (KSA 40-3401-3419) requires all licensees practicing in the State of Kansas to maintain professional liability insurance of not less than $200,000 per claim subject to not less than $600,000 annual aggregate for all claims made during the policy period and to participate in the Kansas Health Care Stabilization Fund (KHCSF). You must submit with your reinstatement application, a copy of the notice of basic coverage, certification of insurance or notification of the insurance binder from your insurance agent and/or company verifying compliance.

8. List ALL employment/professional activity since your Kansas license was cancelled. 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.

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 MD, DO, DC or DPM. 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 MD, DO, DC or DPM license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

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 on detail in 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. A 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 companies?

(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 companies?

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

_____

_____

_____

_____

_____

_____

Applicant Name: _____
(please print or type)

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 ☐

12. Continuing Education.
MDs, DOs and DCs: Provide proof during the 18-month period immediately preceding this application, completion of at least 50 credits of continuing education, of which at least 20 credits shall be in category I and the remaining credits in category II.

DPMs: Provide proof during the 36-month period **immediately** preceding this application, completion of at least 54 hours of continuing education.

13. 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

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 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 $400 and criminal back ground report fee of $48 for MDs, DOs and DCs. Application fee of $300 for DPMs. NPDB report fee of $3 for all. If your previous Kansas license was revoked, a fee of $1000. Make the fees payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

revised 10/14/15, kl

Applicant Name: _____
(please print or type)

Authorization and Release

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 State 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

SEAL here

Sworn to before me this _____day of

_____ 20 _____

_____ Notary Public

_____ Commission Expires

revised 12/28/12 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 physicians. 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 a capable physician 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

_____
address

_____
city, state and zip

_____
phone number

_____
signature

_____
date

Revised 1-25-11 kl

Addendum 3

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

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Addendum 4

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 here)

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

WAIVER AGREEMENT AND STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize 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. Pursuant to K.S.A. 22-4701 *et seq*. and K.S.A. 22-5001, the Kansas State Board of Healing Arts may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the Kansas State Board of Healing Arts of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Kansas State Board of Healing Arts may choose to deny my application or grant me a limited or restricted license until the criminal history background check is completed.

I understand that, upon my request, the Kansas State Board of Healing Arts will provide me with a summary of the information contained in my Criminal History Background Report for the limited purpose of challenging the accuracy and/or completeness of the information contained in the report, but will not provide me with a complete copy of the Criminal History Background Report. I understand that I may obtain a prompt determination as to the validity of my challenge before the Kansas State Board of Healing Arts makes a final decision about my application for a license to practice the healing arts. I further understand that I will not be provided access to information in my Criminal History Background Report under the following circumstances: 1) I am granted a full, unrestricted license, 2) I voluntarily withdraw an application for licensure, or 3) I am denied a license and have exhausted all my right to appeal the denial.

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 3805, and may result in the denial of my application pursuant to K.S.A. 65-2836 (a).

_____ _____
Signature Date

_____ _____
Printed Name Date of Birth

_____
Residential Address City State Zip

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

INSTRUCTIONS FOR REQUESTING A CRIMINAL BACKGROUND CHECK
for MDs, DOs and DCs only

Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks.

Following is the *Waiver Agreement and Statement*. Please complete, sign and date the *Waiver Agreement and Statement* form with your application. Your application will not be deemed as completed without a completed and signed *Waiver Agreement and Statement* form.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. Your local law enforcement agency should be willing to assist you with completing the fingerprints. Some enforcement agencies offer electronic scanning (Livescan). Please visit our website at www.ksbha.org for a listing of Livescan agencies. Have at least one form of picture identification for the law enforcement agency to examine.

If you do not utilize a Livescan agency, contact the Board at 785 296-7413 or 888-886-7205 to receive a fingerprint card or visit http://www.fbi.gov/about-us/cjis/identity-history-summary-checks/fd-258-1 to print a fingerprint card. If printing the card please print on card stock paper.

Please complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submitting the fingerprint card. Be sure to include name (including aliases, maiden and previous names), 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. Sign the card in front of the law enforcement officer. If you use Livescan, the agency may have a different form for you to complete.

Make a check or money order (do not send cash) payable to the Kansas State Board of Healing Arts for $48 as of February 1, 2015. A fingerprint card submitted without payment will not be processed.

Provide the law enforcement officer with a stamped envelope addressed to KSBHA 800 SW Jackson, LL-Suite A., Topeka, KS 66612 to mail your fingerprint card or electronic scan, and fee. In addition, you may want to use a mailing service that allows for delivery confirmation to confirm your fingerprint card and payment have been received at the Board. Bent and folded cards will not be accepted and a new fingerprint card will be mailed to you for prints to be taken again.

A background check is valid for six (6) months. Application for licensure completed after the six (6) month period will be required to submit a new fingerprint card for a new clearance.

Any and all resubmissions of fingerprints cards require a **$48** submission fee to process. Resubmitted fingerprint cards will not be processed without the payment.

Please complete, sign and return the *Waiver Agreement and Statement* form with your application. Your application will not be deemed as complete without a completed and signed *Waiver Agreement and Statement* form.

revised 2/12/15 kl

Board Action Databank Inquiry Form

Complete this form and forward it to the Federation of State Medical Boards for a disciplinary inquiry report at:

Board Action Databank Inquiry
Federation of State Medical Boards
400 Fuller Wiser Rd, Suite 300
Euless, TX 76039

Federation: Please indicate on the lower portion of this form if any final written orders or findings of fact have been filed against the individual whose name is listed below. Return the form to the Kansas State Board of Healing Arts.

_____
applicant's last name

_____
first name

_____
middle name

_____
degree

_____
date of birth

_____
medical school

_____
year of graduation

_____
social security number

_____
ECFMG# (if applicable)

I hereby certify that I am the individual referenced above and I acknowledge that I have answered all questions and reported all information on this page truthfully and completely.

_____
applicant's signature

revised 1-25-11 kl

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Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

GENERAL INFORMATION AND INSTRUCTIONS FOR REINSTATEMENT

Please visit www.ksbha.org for all statutes and regulations governing your particular branch of the healing arts.

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.

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). Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to 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 additional information or documents 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 reinstatement application fee for MDs, DOs and DCs is $400.00 and $300.00 for DPMs.. 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, debit card or credit card.

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.

You can request verification of many state licenses through Veridoc at www.veridoc.org or call 701-319-6500

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. Include a $3.00 report fee for the Board to obtain the NPDB report for all professions if applications is postdated on or after October 1, 2014.

MD licenses expire on June 30 and are renewed annually. Renewal will be required of all applicants receiving permanent licenses prior to April 1. DO and DPM licenses expire on September 3 and are renewed annually. Renewal will be required of all applicants receiving permanent licenses prior to July 1. DC licenses expire on December 31 and are renewed annually. Renewal will be required of all applicants receiving permanent licenses prior to September 1

For Medicine and Surgery (MD) and Osteopathic Medicine and Surgery (DO) only:

You must request a disciplinary inquiry report from the Federation of State Medical Boards (FSMB), see addendum 6. Once the form is completed, it should be mailed to the FSMB.

MDs and DOs must either submit the AMA or AOIA report. To request the AMA report from the American Medical Association visit www.ama-assn.org or call 800-665-2882. To request the AOIA report from the American Osteopathic Information Association visit www.osteopathic.org or call 800-621-1773x8145.

CHECK LIST: Did you complete the following?

ALL questions answered on the application
Provide documentation to any "Yes" answers to #10 or #11
Submit documented proof of CME #12
Enclose a head and shoulder photograph (size: 2x3, taken within 90 days of application) #13
Notarize and sign the Oath #14
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
Submit Criminal Background Waiver Addendum #5 (MDs, DOs and DCs only)
Submit Fingerprints (MDs, DOs and DCs only)
Request the AMA or AOIA report (MDs and DOs only)
Request the Federation report Addendum #6 (MDs and DOs only)
Enclose a payment for the application, the criminal background report and NPDB