GENERAL INFORMATION ACUPUNCTURE (L.Ac)

Thank you for your interest in becoming licensed in Kansas. Please read the following information carefully. This information is vital to the successful completion of your application and often, questions you may have, are covered. For all information governing the practice of Acupuncture in Kansas, please visit the Statute and Regulation Handbook.

If not applying online, the application and all forms are fillable PDFs and can be submitted electronically by emailing KSBHA_Licensing@ks.gov. If a seal or notary is required, it must be clearly visible to be accepted by email. **Pages 1-3 of the application will not be accepted handwritten.**

It is highly recommended that you make and keep copies of all the items you submit for your application. As a reminder, **please do not make a commitment to work dates, prior to being licensed**.

Applications are processed in order of date received. Please allow **at least 2 to 4 weeks** for the processing of your application. After an application is processed, a missing requirement letter ("MRL") is sent to the preferred email address. Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application. For updates, login to the online portal using the registration code listed in the MRL. When a license is issued, a notification with the wallet card is sent to the preferred email address.
If your license is issued before January 1, you will be required to renew by March 31, of the next calendar year. If your license is issued after January 1, you will not be required to renew until the following calendar year. **Renewal starts January 15; late renewal starts March 1. All L.Ac licenses cancel April 1, if not renewed.**

Fees:
Application**: $165**
NPDB: **$3**
ALL FEES ARE NON-REFUNDABLE

If you:	**Then complete the:**
Never held a Kansas Acupuncture license	Initial Application
Previously held a Kansas Acupuncture license that is now cancelled	Reinstatement Application

LAC Application Requirements Check List:

	Complete application, with all questions answered.
	Request official transcript with the final degree awarded directly from the school.
	Request verification of all licenses, permits or certifications, if applicable
	Request verification of certification from NCCAOM.
	Request clean needle technique (CNT) certificate from CCAOM or NCCAOM
	Documentation for any "YES" answers on the attestation questions.
	Documentation of name change, if applicable.
	Documentation of professional liability insurance, active license only.
	Notarize and sign copy of the Affidavit and Authorization.
	Complete and sign Third Party Release, if applicable.

For frequently asked questions, visit: http://www.ksbha.org/faq/faqlicensinglac.shtml

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

APPLICATION INSTRUCTIONS – ACUPUNCTURE (L.Ac)

Application Fees: Application fees must be submitted with the application. These *fees are* ***non-refundable*** and will be processed upon receipt. The Kansas LAC application fee is **$165**. Also, a National Practitioner Data Bank ("NPDB") report fee of **$3** must accompany the application. This totals **$168**. Board staff directly runs an NPDB report for all applicants. **Please do not submit an NPDB self-query.** To pay by debit or credit card, complete the Credit Card/Debit Card Authorization Form. Please make all checks payable to the KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card.

Name: Provide your full legal name. If the name on the application differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name.

Identification: Federal Law, at 42 U.S.C.S. § 666(a)(13), mandates that this agency record social security number on your application. K.S.A. 74-148(a) provides that every application by an individual for a professional license shall request the applicant's social security number. K.S.A. 74-139 requires this agency to disclose 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 by this agency of your social security number is voluntary to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your social security number will not be released for any other purpose not permitted by law.

Addresses: Addresses may **not** be a Post Office Box, except qualified participants under the Safe at Home Act, K.S.A. 75-451 *et seq*. Your home address will not be available to the public. The business address is public and will be posted on the Board's website. The Board will contact you at the designated preferred mailing and email address. If your address or contact information changes, you must notify the Board within 30 days by completing the Change of Address Form or in the online portal.

National Provider Identifier (NPI): The NPI is a unique 10-digit numeric identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. Provide your NPI number or if you do not have an NPI number check the corresponding box.

Examination: List your NCCAOM certification number, issue date, expiration date, and clean needle technique (CNT) completion date. Request the NCCAOM send the Board an official verification of your certification, by visiting https://www.nccaom.org. If your CNT course is not included with the NCCAOM certification, request the CCAOM send the Board official verification of your CNT certification, by visiting https://www.ccaom.org/. **Verifications must be received directly from the NCCAOM or CCAOM.**

Postsecondary Education: In chronological order, list all postsecondary schools you have attended, even those from which you did not graduate. Attach an additional page if necessary. Request an official transcript with the final degree awarded be mailed or sent electronically from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors. Send electronic transcripts to KSBHA_Licensing@ks.gov.

Healthcare Employment/Professional History: In chronological order, list all healthcare employment/professional history for the past five years. Explain all gaps longer than 6 months. Attach additional page if necessary. Include actual work address, not corporate headquarters.

Other Licenses/Permits/Certifications: List all state or jurisdictions in which you currently, or have ever held, a license, permit, or certification, permanent or temporary. The Board will verify your credentials for any state or jurisdiction that provides free and current verifications on their official state website and includes the following information: issue date, expiration date, and any pending or past disciplinary action. If the Board is unable to verify your credentials, you may complete the verification form and forward to all licensing agencies. Please check with the licensing agency to see if a fee is required for this information prior to sending the form. The Board accepts electronic verifications directly from the licensing agency.

License Designation: Read each description and select the appropriate license designation.

Attestation Questions: The mission of the Board is to protect the public, which it does so in part, through effective licensure and enforcement. The public is safeguarded by issuing licenses to qualified, competent, and ethical applicants. In the application, you will be asked a series of attestation questions. A "yes" answer to an attestation question is not an automatic disqualification for licensure – each applicant is considered on an individual basis. You may be requested to submit additional information or documents. It is your continued duty to update the Board on any changes once the application has been submitted. Please keep in mind, **failure to fully disclose may constitute grounds for denial of your application**.

Affidavit and Authorization for Release of Information: Attach a 2 x 3-inch colored photograph, with head and shoulder areas only, taken within the last 90 days. Black and white photographs, proof photographs, negatives, photographs cut from books or newspaper articles, or poor-quality photographs are **NOT** accepted. In the presence of a notary public, sign and date this form with the attached photograph.

Professional Liability Insurance (Active license only): K.A.R. 100-76-5 requires L.Ac's with an active license maintain professional liability insurance of not less than $200,000 per claim, and not less than $600,000 annual aggregate for all claims made during the policy period. Proof of coverage or intent to cover is required for active licensure.

Third Party Release: Complete this form if you would like Board staff to talk with third parties about your application.

How to Check the Status of Your Application: Once your application is received and processed, you will be notified via email of any missing items and how to check the status of your application online.

ACUPUNCTURE INITIAL LICENSURE APPLICATION

Completed application and forms can be emailed to KSBHA_Licensing@ks.gov or mailed to the Kansas State Board of Healing Arts. If a seal or notary is required, it must be clearly visible to be accepted by email. **Pages 1-3 of the application will not be accepted handwritten.**

FULL LEGAL NAME/IDENTIFICATION

Provide your full legal name. If the name on the application differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name.

First Name:	Middle Name:	Last Name:	Suffix:
List all other names used, including maiden name:			
Social Security Number:	Date of Birth: MM/DD/YYYY		
Place of Birth (City, State/Jurisdiction, Country):		Male ☐ Female ☐	

ADDRESSES

Addresses may not be a Post Office Box, except qualified participants under the Safe at Home Act, K.S.A. 75-451 *et seq*. Your home address will not be available to the public. The business address is public and will be posted on the Board's website. The Board will contact you at the designated preferred mailing and email address.

Home Address	Street & Number:		
	City:	State:	Zip:
	Phone:	Email:	
Business Address No Business Address ☐	Street & Number:		
	City:	State:	Zip:
	Phone:	Email:	
Preferred Mailing Address: (must select one)	Home Address ☐	Business Address ☐	
Preferred Email Address: (must select one)	Home Email ☐	Business Email ☐	

LEGAL AUTHORITY TO WORK IN THE U.S.

Are you a US Citizen? Yes ☐ No ☐	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 Unites States.
☐	Other:

NATIONAL PROVIDER IDENTIFIER (NPI)

The NPI is a unique 10-digit numeric identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. Provide your NPI number or if you do not have an NPI number check the corresponding box.

NPI Number:	I do not currently have an NPI number ☐

EXAMINATION

List your NCCAOM certification number, issue date, expiration date, and clean needle technique (CNT) completion date. Request the NCCAOM send the Board an official verification of your certification If your CNT course is not included with the NCCAOM certification, request the CCAOM send the Board official verification of your CNT certification. If you have not tested check the corresponding box and list the date you are scheduled to sit for the exam.

NCCAOM Number:	Original issue Date:	Expiration Date:
Date of CNT Exam:	I have not tested ☐	Date scheduled to sit for exam:

POSTSECONDARY EDUCATION

In chronological order, list all postsecondary schools you have attended, **even those from which you did not graduate**. Attach additional page if necessary. Request an official transcript with final degree awarded be mailed or sent electronically from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors. Send electronic transcripts to KSBHA_Licensing@ks.gov.

College/University:		College/University:	
City, State:		City, State:	
Start: MM/DD/YYYY	End: MM/DD/YYYY	Start: MM/DD/YYYY	End: MM/DD/YYYY
Degree Earned:		Degree Earned:	

HEALTHCARE EMPLOYMENT/PROFESSIONAL HISTORY

In chronological order, list all healthcare employment/professional history for the past five years. Explain all gaps longer than 6 months. Attach additional page if necessary**. Include actual work address, not corporate headquarters**. If you have never previously worked in a healthcare position check the corresponding box.

I have never previously worked in a healthcare position ☐				
From MM/YYYY	To MM/YYYY	Address	Employer	Job Description/Title

OTHER LICENSES/PERMITS/CERTIFICATIONS

List all state or jurisdictions in which you currently, or have ever held, a **healthcare related license, permit or certification, permanent or temporary.** The Board will verify your credentials for any state or jurisdiction that provides free and current verifications on their official state website and includes the following information: issue date, expiration date, and any pending or past disciplinary action. If the Board is unable to verify your credentials, you may complete the verification form and forward to all licensing agencies. Please check with the licensing agency to see if a fee is required for this information prior to sending the form. The Board accepts electronic verification directly from the licensing agency. If you have never held a healthcare related license, permit or certification in another state or jurisdiction check the corresponding box.

I have never held a healthcare related license, permit or certification in another state or jurisdiction ☐				
State	Type of License	License Number	Issue Date MM/DD/YYYY	Expiration Date MM/DD/YYYY

LICENSE DESIGNATION

Read each description and select the appropriate license designation.

Active ☐	Engaged in the practice of acupuncture. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education upon renewal and are required to maintain professional liability insurance, see K.A.R. 100-76-5.
Exempt ☐	Does **not** regularly engage in the practice of acupuncture and does not hold oneself out to the public as being professionally engaged in such practice. Entitled to all the privileges of acupuncture and may serve as a paid employee of (1) A local health department as defined by K.S.A. 65-241 or (2) an indigent health care clinic as defined by K.S.A. 75-6102. **Required** to complete continuing education. **Not** required to maintain professional liability insurance.
Inactive ☐	**Not** engaged in the practice of acupuncture and does not hold oneself out to the public as being professionally engaged in such practice. Not required to complete continuing education. **Not** required to maintain professional liability insurance.

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.

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 to KSBHA_Licensing@ks.gov or mail it 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 Acupuncture 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 Acupuncture 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 Acupuncture.

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 last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature ***(must correspond to date of notarization)***

[Please note: The notary must be clearly visible when submitting electronically]

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 _____

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

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

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

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

☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS ☐ MasterCard

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)

Applicant/Licensee Name: _____

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			

Kansas State Board of Healing Arts
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