



APPLICATION FOR ACUPUNCTURE

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. 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.

_____ 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.

Residential Address: _____
street city state zip country

Mailing Address: _____
public information street city state zip country

Email Address: _____

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: _____ Sex: M F
city state/jurisdiction country

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

Are you a U.S. 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 United States.

Other: _____

5. NCCAOM Status

National Certification Commission of Acupuncture and Oriental Medicine certification (NCCAOM) number: _____

Original Date Issued: _____ Expiration: _____

Date of Clean Needle Exam (CCAOM/NCCAOM): _____

I have not yet taken the NCCAOM exams: _____ Date scheduled to sit for the exams: _____

6. List ALL post-secondary schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary. Enclose or send only an official and final transcript showing the degree awarded required for licensure. Do not provide additional education transcripts.

School Name: _____

Address: _____
street city state zip country

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

School Name: _____

Address: _____
street city state zip country

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

7. List all employment/professional activity during the past five years. Account for all time and explain all periods of unemployment or gaps in professional activity. Attach an additional sheet if necessary. Include actual work address, not corporate headquarters address.

I have not been employed or had professional activities during the past five years

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

Employer: _____ Job description/Title: _____

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

8. List all states or jurisdictions in which you currently hold or have ever held a professional license, registration or certificate. 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 professional license, registration or certificate. 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
_____	_____	_____	_____
_____	_____	_____	_____

9. Certificate of Professional School (Post-Secondary School)

It is hereby certified that _____ attended _____, in
 (applicant's name) (school's name) (city and state)

Beginning _____ with a completion or anticipated completion date of _____ during which time
 (date - mmyy) (date - mmyy)

the applicant pursued and completed all requirements for the program of Acupuncture or Oriental Medicine according to the standards of accreditation prevailing at the time. It is further certified that the applicant received or will receive the following degree:

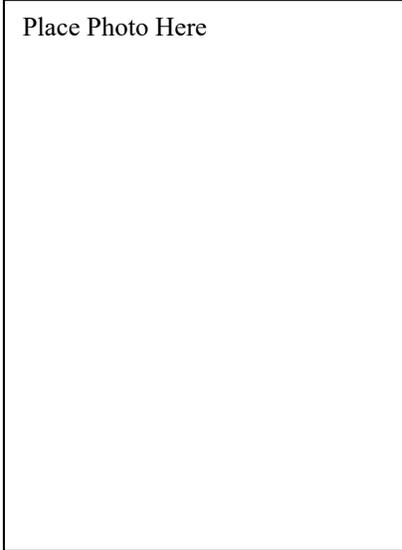
 (specify degree, certificate, letter of certification or other)

 (signature of President, Registrar, Dean, Director of Course)

Name of School: _____

School Seal here
 (if no school seal, statement must be notarized by the school)

10. Photo: Attach a 2"x 3" wallet size color 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.





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 currently have any physical or mental health condition (including alcohol or substance use) that impairs your judgment or would otherwise adversely affect 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 martialled 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.****

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

ACTIVE: A license issued to a person 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 have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

INACTIVE: A license issued to a person who meets all the requirements for a license to practice as an acupuncturist and who does not actively practice as an acupuncturist in this state. An inactive license shall not entitle the holder to render professional services as an acupuncturist. The holder of an inactive license shall not be required to submit evidence of basic coverage or self-insurance. Each inactive license may be renewed annually.

EXEMPT: A license issued to a person who is not regularly engaged in the practice of acupuncture in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. The holder of an exempt license may serve as a paid employee or unpaid volunteer of a local health department as defined by K.S.A. 65-241, or an indigent health care clinic as defined by K.S.A. 75-6102. The holder of an exempt license shall be required to submit evidence of satisfactory completing required continuing education. Each exempt license may be renewed annually.

13. Proof of Malpractice Insurance

Please attach a separate page with a copy of your policy binder or basic notice of coverage. It should include name of insurance carrier, effective dates of coverage, and coverage limits.

14. Oath must be signed by applicant and notarized.

I, _____, (Applicant) 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 acupuncture 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

SEAL here

State of _____;
County of _____.

Sworn to before me on this _____ day of _____, 20_____.

Notary Public

My commission expires on: _____

15. Application fee of \$165. NPDB report fee of \$3. Make the fee payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.



Third Party Authorization
Must be signed by applicant and notarized.

I, _____, hereby authorize all hospitals, institutions or organizations, 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

Sworn to before me this _____day of

_____ 20 _____

_____ Notary Public

_____ Commission Expires

SEAL here



GENERAL INFORMATION AND INSTRUCTIONS
Acupuncture License

Please visit <http://www.ksbha.org/professions/ACC.shtml>
for all information governing an Acupuncture License

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 commit to any work dates prior to being 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).

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 our 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.

Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to the Kansas State Board of Healing Arts. Some forms can be submitted to the Board by fax or as an attachment in an e-mail. Documents not accepted by fax or e-mail: oath, release, and photo. Other documents may be received by email from the originating entity.

Kansas application fee is \$165.00. NPDB fee of \$3. Kansas application fees must be submitted with the application, are **NOT** refundable and will be processed upon receipt. 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, or credit card. To pay by debt or credit card please complete the credit card authorization form.

Each person who received training from a non-approved school and who applies for licensure as an acupuncturist shall submit with the application such information as listed in K.S.A. 65-7607. For applicants who received training in a school at which English was not the language of instruction, an examination is required to demonstrate the ability to communicate in written and oral English. The test of English as a foreign language is developed and administered by the education testing agency (ETS). You can visit www.ets.org for more information.

Visit www.nccaom.org to register for the NCCAOM examinations or to request verification of passed exams. Before a permanent license will be issued, passing NCCAOM exams and a final transcript with the degree posted will need to be submitted.

Each person who applies for an active license as an acupuncturist shall before receiving their license shall, submit to the Board evidence of professionally liability insurance coverage as required by K.S.A. 2017 Supp. 65-7609, and amendments thereto, for which the limit of the insurer's liability is at least **\$200,000 per claim, subject to an annual aggregate of at least \$600,000** for all claims made during the period of coverage.

You must submit any change of address to the Board. Please visit our website to complete the "Change of Address" Form.

Licenses/Certificates expire March 31 and are renewed annually. Licenses renewal will be required of all receiving a permanent license prior to January 1.



CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

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



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			



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/Registration No.: _____ Date Issued: ____/____/____

Profession: _____

Signature: _____

Full Name of Licensee or registrant: _____

License or Registration No.: _____ Status: _____

License 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 on your state?

YES NO Unable to Divulge

Have formal disciplinary proceedings ben initiated against the applicant or applicant's license or registration by a disciplinary authority in your state?

YES NO Unable to Divulge

Comments: _____

Signature: _____ Title: _____

State Board of _____ Date: _____



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



ADDENDUM 1

Recommendation by a peer that has known the applicant for a minimum of 1 year.

I, _____, a practicing
(Please print name of peer)

acupuncturist in the state of _____
(state name)

affirm that _____
(Please print name of applicant)

has been known to me for _____ year(s), and that the applicant to the best of my knowledge is
an ethical practitioner, is of good professional character, and is not addicted to the use of alcohol or drugs.

Signature

Street Address

Date

City, State, Zip