



### APPLICATION FOR RADIOLOGIC TECHNOLOGIST

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.

Are you requesting a Temporary Permit? (Temporary Permits are not issued to applicants by endorsement). Y  N

**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: \_\_\_\_\_ 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? Y  N  If you answered NO, are you (check one):

A qualified alien (as defined in 8 U.S.C.A. § 1641).

A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 *et seq.*).

An alien who is paroled into the United States under 8 U.S.C.A. § 1182(d)(5) for less than one year.

A foreign national, not physically present in the United States.

Other: \_\_\_\_\_

**5. List all Board (ARRT or NMTCB) examination attempts. Request an official copy of your ARRT or NMTCB scores be sent directly to the board and enclose a notarized copy of your current ARRT or NMTCB card.**

I have not yet tested.  Date scheduled to sit for the examination: \_\_\_\_\_

Date \_\_\_\_\_ Passed \_\_\_\_\_ Number of attempts for initial testing.

**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: \_\_\_\_\_  
month year month year

School Name: \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip country

Attendance Dates: \_\_\_\_\_ To \_\_\_\_\_ Degree: \_\_\_\_\_  
month year month year

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

I have not been employed 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 are currently or have ever been licensed, registered or certified as a radiologic technologist. 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 radiologic technologist license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.**

I have never been licensed, registered or certified in another state, or jurisdiction.

State/Jurisdiction	License, Registrant, Certificate no.	Status	Issue Date
_____	_____	_____	_____
_____	_____	_____	_____

Applicant Name: \_\_\_\_\_  
(please print or type)



## EXPEDITED LICENSURE QUESTIONNAIRE

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To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406<sup>i</sup>, 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.

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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. If you do not currently reside in Kansas, 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 Kansas 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.

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<sup>i</sup> 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

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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.

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Full Name of Applicant

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Date

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, excluding academic probation in medical school, prior to completing the training? Yes \_\_\_ No \_\_\_
2. Have you ever had any application for any professional license, registration, or certificate denied by any licensing authority? Yes \_\_\_ No \_\_\_
3. Have you ever been denied the privilege of taking an examination required for any professional license, registration, or certificate? Yes \_\_\_ No \_\_\_
4. While working in a healthcare facility as a staff member (including postgraduate training) did you ever have your privileges censured, limited, suspended, revoked, or received other disciplinary action? Yes \_\_\_ No \_\_\_
5. While working in a healthcare facility as a staff member (including postgraduate training) did you ever voluntarily or involuntarily resign while under investigation? Yes \_\_\_ No \_\_\_
6. Have you ever been denied privileges with any health care facility? Yes \_\_\_ No \_\_\_
7. 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 \_\_\_
8. Have you ever voluntarily surrendered any professional license registration, or certificate, in lieu of formal disciplinary proceedings? Yes \_\_\_ No \_\_\_
9. Has any licensing authority ever limited, suspended, revoked, censured or placed you on probation, or have you had any other disciplinary action taken against any professional license, registration, or certificate you have held? Yes \_\_\_ No \_\_\_
10. Have you ever been requested to appear before a licensing authority? Yes \_\_\_ No \_\_\_



11. To your knowledge, have any complaints or charges ever been filed against you, or are you currently under investigation, with any licensing agency, professional association, or health care facility? Yes \_\_\_ No \_\_\_
12. Has any professional association imposed any disciplinary action against you? Yes \_\_\_ No \_\_\_
13. Do you currently have any physical or mental health condition (including alcohol or substance use) that impairs your ability to practice your profession in a competent, ethical, and professional manner? Yes \_\_\_ No \_\_\_
14. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate? Yes \_\_\_ No \_\_\_
15. Have you ever had your Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration revoked, suspended, or restricted in any way, or surrendered in lieu of formal proceedings? Yes \_\_\_ No \_\_\_
16. Have you ever been arrested? You must include all arrests including those that have been set aside, dismissed, expunged, pardoned, 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? You must include those that have been set aside, dismissed, pardoned, or expunged, or where a stay of execution has been issued. Yes \_\_\_ No \_\_\_
18. Have you ever been court martialled or dishonorably discharged 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 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 or federal Medicaid or Medicare 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 completed form to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail 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 Radiologic Technologist 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 Radiologic Technology 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 Radiologic Technology.

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

\_\_\_\_\_  
Date of signature (must correspond to date of notarization)

**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 \_\_\_\_\_



**LETTER OF COMPLETION**

For the purpose of obtaining a temporary license, the Letter of Completion may be submitted 3 weeks prior to graduation or any time after graduation, in lieu of an official transcript, when it is confirmed that all degree requirements have been met and the official transcript with the final degree awarded is not yet available.

**Applicant:** Complete the top portion and submit to the school or program.

**School or Program:** For the purpose of obtaining a temporary license, this form may be completed **3 weeks prior to graduation or any time after graduation, in lieu of an official transcript, when it is confirmed that all degree requirements have been met and the official transcript with the final degree awarded is not yet available.** Complete the bottom portion and email to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail directly to the Kansas State Board of Healing Arts. The seal or notary must be clearly visible to be accepted by email.

I hereby authorize the school or program listed below to provide the Kansas State Board of Healing Arts any and all information pertaining to my education at that institution.

Full Name: \_\_\_\_\_

Other Names Used (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of School or Program: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY THE PRESIDENT, REGISTRAR, DEAN OR DIRECTOR OF COURSE**

Name of Applicant: \_\_\_\_\_

Name of School or Program: \_\_\_\_\_

Address: \_\_\_\_\_

Start Date: \_\_\_\_\_ Completion or Expected Completion Date: \_\_\_\_\_

Degree Awarded: \_\_\_\_\_

By signing below, I certify under penalty of perjury under the laws of the State of Kansas that the information provided is a true and correct statement of the record of the above-named applicant. It is further certified that the applicant completed all requirements according to the standard of accreditations prevailing at the time and will receive the above-stated degree.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name & Title

(Seal)

\_\_\_\_\_  
Email





## LICENSE VERIFICATION FORM

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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](mailto: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: \_\_\_\_\_

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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: \_\_\_\_\_



## THIRD PARTY RELEASE

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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](mailto:KSBHA_Licensing@ks.gov) or mail it directly to the Board.

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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



## GENERAL INFORMATION AND INSTRUCTIONS

Please visit [www.ksbha.org](http://www.ksbha.org) for all statutes and regulations governing [Radiologic Technologists](#).

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 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 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 was so long ago." There is no excuse for not disclosing.

Kansas application fees must be submitted with the application, are **NOT** refundable, and will be processed upon receipt. The Kansas application fee is \$60, NPDB report fee is \$3, and temporary permit fee is \$25, if applicable. To pay by debit or credit card please complete the credit card authorization form. If paying by check make check 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.

Temporary Permits are available to those that have graduated but not yet taken the national exam. Temporary Permits are not issued to applicants by endorsement. One (1) temporary permit may be issued by the Board to applicants who meet all the requirements as required under K.S.A. 65-7305 and amendments thereto. Temporary Permits expire 180 days after the date of issue or certification.

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

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: exam certification, certification of school, oath, release, photo, transcripts, and verifications from other states.

Select which organization you have tested and earned certification with. List the number of attempts, date passed, credentials earned, and ID number. Upon initial review of the application the Board will attempt to verify your AART or NMTCB credentials, if the Board is unable to verify your credentials you will be notified. If you have not maintained ARRT certification request a duplicate score report be sent directly to the Board. If you have not yet tested check the corresponding box and the date you are scheduled to test. After testing and earning certification request verification on ARRT letterhead be emailed to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov).

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. All applicants include a \$3 report fee for the Board to obtain the NPDB report.

Licenses/Certificates expire September 30 and are renewed annually. License renewal will be required of all receiving a permanent license prior to June 1.

### CHECK LIST - Did you complete the following?

**ALL** questions answered on the application

Request official & final transcript submitted by the post-secondary school

Request verification from states, countries or jurisdictions, if applicable

Provide documentation for any "YES" answers to the Attestation Questions

Notarize and sign the Affidavit and Authorization with color photo

Fees

Request verification of certification and registration from ARRT or NMTCB, if applicable.

Post-secondary school signature and seal

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





Email: [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov)



## CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Submit the completed form to the Board. Payments are processed in order of date received.

### CREDIT CARD INFORMATION:

<b>Card Type:</b>				
<b>Card Number:</b>				
<b>Expiration Date:</b> (MM/YY)			<b>Verification Code:</b>	
<b>Purpose of Payment:</b> <i>(Application, NPDB, KBI, Verification of License Fee, etc.) To view license Fee List, <a href="#">click here.</a></i>				<b>Amount:</b>
<b>Name of Cardholder:</b>				
<b>Mailing Address</b>	Street Address:			
	City:		State:	Zip:
	Phone:		Email:	

### APPLICANT/LICENSEE INFORMATION:

<b>Name of Applicant/Licensee:</b>	<b>License Number:</b>
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By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge the above-mentioned amount. I understand that failure to submit the required information will delay processing of the payment.

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please note: The information on this form is considered personal and not subject to disclosure under the Kansas Open Records Act.