RESIDENT ACTIVE LICENSE 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.** As a reminder, **please do not make a commitment to work dates, prior to being licensed.**

IDENTIFYING INFORMATION

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. Documentation is not required if it has been previously submitted.

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:		Male ☐	Female ☐

ADDRESSES

Addresses cannot 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. You may consider listing the postgraduate program as the business address. The Board will contact you at the preferred address.

Home Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	
Business Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	
Preferred Address: (mailed and emailed correspondence will be sent to the selected address)		Home ☐	Business ☐

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 Centers for Medicare and Medicaid Services ("CMS"). Provide your NPI number or if you do not have an NPI number check the corresponding box.

I do not have an NPI Number ☐	NPI number:

EXAMINATION

Select which licensing exam you have taken. List the number of attempts you have taken each portion and the date passed. Request an official copy of your exam scores be sent directly to the Board.

Exam Taken: ☐ USMLE ☐ NBOME/COMLEX -USA ☐ NBME ☐ LMCC ☐ Other:				
	Part 1/Step 1/Level 1	Part 2/Step 2 CK/Level 2 CE	Part 2/ Step 2 CS/Level 2 PE	Part 3/Step 3/Level 3
Attempts				
Date Passed				

MEDICAL EDUCATION

List all medical schools you have attended, **even those from which you did not graduate**. Attach additional page if necessary. Request an official transcript with the final medical degree awarded be sent from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors. An official transcript is not required if one has been previously submitted.

Name of Medical School:			
City:	State:	Start Date:	End Date:
Degree Awarded:		Date Awarded:	

Name of Medical School:			
City:	State:	Start Date:	End Date:
Degree Awarded:		Date Awarded:	

POSTGRADUATE TRAINING

In chronological order, list all postgraduate programs you have attended, even those from which you did not complete. If in progress, list the expected completion date as the end date. Attach additional page if necessary. Request each postgraduate program you've attended complete the Postgraduate Training Verification Form.

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other:			
Name of Institution:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:			
Start Date:	End Date:	Successfully Completed? ☐ Yes ☐ No ☐ In progress	
Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other:			

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other:			
Name of Institution:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:			
Start Date:	End Date:	Successfully Completed? ☐ Yes ☐ No ☐ In progress	
Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other:			

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other:			
Name of Institution:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:			
Start Date:	End Date:	Successfully Completed? ☐ Yes ☐ No ☐ In progress	
Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other:			

Training Type: ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other:			
Name of Institution:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:			
Start Date:	End Date:	Successfully Completed? ☐ Yes ☐ No ☐ In progress	
Accredited By: ☐ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ RACS ☐ Other:			

EMPLOYMENT/PROFESSIONAL HISTORY

In chronological order, list all healthcare employment/professional history since graduating medical school. Account for all months and explain all gaps. Attach additional page if necessary. Include the actual work address, not corporate headquarters. If you have not worked in a healthcare position since graduating medical school check the corresponding box.

I have not worked in a healthcare position since graduating medical school ☐

Employer	Job Description/Title	Address	Start Date	End Date

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.** If you have never held a healthcare related license, permit or certification in another state or jurisdiction check the corresponding box. The Board will attempt to verify your credentials. If the Board is unable to verify your credentials you will be notified.

I have never held a healthcare related license, permit or certification in another state or jurisdiction ☐

State	Issue Date	License Type	License Number

PROFESSIONAL LIABILITY INSURANCE & FUND COMPLIANCE

All new policies and policies that renew on and after January 1, 2022, K.S.A. 40-3402 requires **MD, DO, DC, DPM and PAs** with an active license in Kansas to maintain professional liability insurance of not less than $500,000 per claim, and not less than $1,500,000 annual aggregate for all claims made during the policy period. These professions are also required to maintain compliance with the Kansas Health Care Stabilization Fund (KHCSF). K.S.A. 40-3404; K.S.A. 65-2809(c); K.S.A. 65-2005(d); K.S.A. 65-28a03(b).

I certify that I have read and understand the professional liability insurance and KHCSF requirements and will maintain compliance while holding an active license in Kansas.	☐

U.S. ARMED FORCES SERVICE

U.S. Armed Forces Service: ☐ Yes ☐ No	Branch:	
Start Date:	End Date:	Type of Discharge: