

5. ECFMG, if applicable. Provide the ECFMG report and a notarized copy of the ECFMG certificate

Certificate no.: _____ Issue Date: _____

6. List all medical schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary. Enclose an official and final transcript with awarded degree 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

7. List ALL postgraduate programs you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary.

Intership Residency Fellowship Research Other

Name of Program: _____ Department/Specialty: _____

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Successfully completed? Y N
month year month year

Intership Residency Fellowship Research Other

Name of Program: _____ Department/Specialty: _____

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Successfully completed? Y N
month year month year

8. 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 headquarter's address.

I have not been employed during the past five years.

Employer: _____ Job description/Title _____

Address: _____ Dates: From _____ To _____
city state

Employer: _____ Job description/Title _____

Address: _____ Dates: From _____ To _____
city state

Employer: _____ Job description/Title _____

Address: _____ Dates: From _____ To _____
city state

9. List all states or jurisdictions in which you are currently or have ever been licensed, registered or certified as a medical doctor. 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 medical doctor license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

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

10. Fee of \$30.00 and for all applications postdated on or after October 1, 2014 include a \$3.00 report fee for the Board to obtain the NPDB report.

Make the fee payable to: Kansas Board of Healing Arts or charge by credit/debit card using the attached authorization form.



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 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.****



Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar. Send this notarized form to the Kansas State Board of Healing Arts, 800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to:

Kansas State Board of Healing Arts 800 SW Jackson, Lower Level - Suite A Topeka, KS 66612

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 Uniform Application for Physician State 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 such a change occurs at any time prior to a license to practice medicine 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 or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in this square.

Applicant's signature (must be signed in the presence of a notary)

Applicant's printed last name

Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

Date of signature (must correspond to date of notarization)

-fold up-

-fold up-

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

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: _____

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: _____



STATE BOARD OF HEALING ARTS

GENERAL INFORMATION AND INSTRUCTIONS FOR REINSTATEMENT

Please visit www.ksbha.org for all statutes and regulations governing the practice of the [Healing Arts](#)

Thank you for your interest in becoming licensed in Kansas. Please read the following information very carefully. This information is vital to the successful completion of your application. Often your questions are covered in this form. Please allow two (2) weeks after the submission of the application before contacting our office. Do not 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 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 happened 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 \$30.00. 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.

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 Board of Healing Arts.

To obtain the ECFMG report visit www.ecfmg.org or call 215-386-5900.

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. For all applications postdated on or after October 1, 2014 include a \$3.00 report fee for the Board to obtain the NPDB report.

CHECK LIST

Did you complete the following?

Complete application, with all questions answered.

ECFMG report and notarized certificate if applicable
Documentation for any "YES" answers on the attestation questions.
Notarize and sign copy of the Affidavit and Authorization

Recommendation signatures
Request verification(s) of all licenses, permits or certifications.
Complete and sign Third Party Release, if applicable.
Documentation of name change, if applicable.
Fees

Revised 9/30/14 kl



CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

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



CARD NUMBER

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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
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852
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: _____



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