



KANSAS LICENSURE APPLICATION INSTRUCTIONS MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Application

Review the following instructions carefully before completing the application. This information is vital to the successful completion of your application. Failure to submit all required information and documentation will result in processing delays. 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.**

Kansas does not have direct reciprocity with any state. All applicants are considered on an individual basis. You may be requested to submit information or documentation in addition to the requirements mentioned herein before the application will be deemed complete. **It is highly recommended you make and keep copies, for your records, of all items submitted for review. Do not send original forms or documentation to the Board.**

In completing the application, you will be asked to account for all time since medical school graduation and list all **Malpractice Liability Claims Information**. Having this information on hand before you begin your session will facilitate completing your application.

If you have any questions about the information provided to you in the application packet, please contact our office at 785/296-7413. Thank you for applying for licensure in the State of Kansas.

The Federation Credentials Verification Service (FCVS)

The Board accepts the use of FCVS as part of the licensure process. FCVS staff creates a permanent profile of primary source verified documents related to identity, medical education, postgraduate training, and more. The profile can be updated as needed and sent to boards and other entities without the need to verify each item again.

Applicants using FCVS to verify their credentials are still required to complete the Kansas State Board of Healing Arts Uniform Application (UA). If you do not use FCVS, you must provide your credentials to the Board for verification along with completing the UA.

For clarification, the Uniform Application (UA) is used to apply for state licensure. The FCVS application is used only to create or update a personalized profile of primary source verified credentials for use in the overall licensing process.

To use FCVS, visit <http://www.fsmb.org/> and select "FCVS" in the Licensure or Sign In menu, then sign in and continue as directed. Users with existing FCVS profiles should complete a Subsequent FCVS Application to ensure the profile is up to date. New FCVS users should complete the Initial FCVS Application. All users must, during the application process, designate the Kansas State Board of Healing Arts to receive the FCVS profile. Self designations are not accepted.

More information about FCVS is available at <http://www.fsmb.org/licensure/fcvs/>. For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT on weekdays.

The Uniform Application for Physician State Licensure (UA)

This packet contains a version of the UA that can be completed and mailed to the Board instead of completing the UA online. There is no fee for using the paper UA.

Please note the following:

- The Board requires that you submit your valid National Provider ID number in the space provided.
- Accepted examinations are National Boards (NBME, NBOME), FLEX, USMLE, State Examinations, LMCC, COMLEX, or a combination of FLEX, USMLE, and National Boards. Applicants who took the FLEX prior to June 1985 must have passed with a FLEX weighted average of 75 or higher, attained in one sitting. Applicants who took the USMLE must complete all steps within 10 years.
- List all professional licenses (nurse, EMT, physician assistant, etc.) you have held in the U.S. or Canada, regardless of status (active, inactive, etc.). If you hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper to the Board. Use the Licensure Verification form in this packet to request license verifications from each board.
- On the Chronology of Activities, for military or locum tenens assignments, list each location/assignment separately. Additionally, for military service, please provide a copy of your discharge or separation documents.
- For all locations where you have had admitting privileges, check the “Staff Privileges” box.
- For all malpractice, claims include a written statement from the insurance company or insurance / personal / institution attorney. Include date of occurrence, name of the insurance company involved on your behalf, name of claimant(s), other defendant(s) and/or institution involved, list of all attorneys involved, case number and location of filing, status of the matter, and summary of the occurrence; or you may provide court documents. Failure to provide complete information will result in delay of processing the application.

In addition to completing the core UA, all applicants must:

- Complete the state addendum.
- Submit a notarized UA Affidavit and Authorization for Release of Information form to the Board. This is a separate form from the FCVS Affidavit and must be sent to the Kansas State Board of Healing Arts. Attach a recent (less than 6 months old) two inch by two inch (2” x 2”) passport-type color photograph of yourself in the space provided. Proof photos, negatives, and digital photos are not acceptable.

Please note that by signing the Affidavit and Authorization for Release of Information form, you agree to the following:

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 medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry in the state of Kansas and may subject me to a fine not exceeding \$10,000 and term of imprisonment not exceeding 5 years for each violation. (K.S.A. 21-3805)

- KSBHA will verify each of your medical board licenses except for any board that does not provide free, current verifications and disciplinary actions on their official website. For those boards, use the licensure verification resource at <http://www.fsmb.org/licensure/uniform-application/> to determine the fees and preferred verification method of each board. Use the Licensure Verification form in this packet for boards requiring a written request. You may use VeriDoc or another preferred method if applicable.

If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education, Postgraduate Training, or Fifth Pathway Verification forms, or send identity documents, transcripts, certificates, or examination scores to the Board. FCVS obtains this information and sends it to the Board as part of your FCVS profile of verified credentials.

If you are not using FCVS for credentials verification,

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if your name is not the same on all of your submitted documents.
- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form.
- Submit a notarized copy of your medical school diploma(s). The diploma(s) must be notarized as a true and accurate copy of the original. Note: Diplomas in languages other than English must be translated and the translation certified as accurate. Documents without such certification will not be accepted.
- Contact each appropriate examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at <http://www.fsmb.org/licensure/uniform-application/faq>.
- International Medical Graduates: Submit a notarized copy of your ECFMG Certificate to the Board. It must be notarized as a true and accurate copy of the original. Also request that a “Status Report of ECFMG Certification” be sent directly to the board. If you attended a Fifth Pathway Program, request that the Fifth Pathway Program Certificate be sent to the Board. See the UA FAQ link above for contact information.

Additional Licensure Information / Requirements

- **Application Fee.** The Kansas application fee is \$300.00. It must be submitted with the application and is **NOT** refundable. You may pay by check, debit card, Visa, MasterCard, Discover, American Express or money order. 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, debit card or credit card.
- **AMA and AOIA Reports.** MDs must request the AMA report from the American Medical Association at <https://profiles.ama-assn.org/amaprofiles/> or call 800-665-2882. DOs must request the AOIA report from the American Osteopathic Information Association at <https://www.doprofiles.org> or call 800-621-1773 x8145.
- **Criminal Background Report.** Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. Addendum 5 explains in detail how to obtain and submit your fingerprints to the Board. **Be aware that fingerprint processing may delay your application. Please make it a PRIORITY to complete the fingerprint process. Complete, sign and return the *Waiver Agreement and Statement* form directly to the Board.**
- **National Practitioner Data Bank Report.** Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank (NPDB). This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. **The Kansas State Board of Healing Arts will obtain a NPDB report for all applicants. Applicants will be required to submit the report fee of \$3.00 to the Board.**
- **License Renewals.** MD licenses expire on July 31 and are renewed annually. License renewal will be required of all MD applicants receiving permanent licenses prior to May 1. DO licenses expire on October 31 and are renewed annually. License renewal will be required of all DO applicants receiving permanent licenses prior to August 1.

UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE CHECKLIST

After completing the Uniform Application, you are responsible for submitting certain documents. There are two checklists below; one to use if you are using the Federation Credentials Verification Service (FCVS) and one to use if you are not using FCVS. Please use the checklist that applies to you.

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed Uniform Application (UA).	<input type="checkbox"/>	<input type="checkbox"/>
Completed state addenda and fees (licensure fee of \$300 plus National Practitioner Data Bank Report fee of \$3) sent to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Notarized UA Affidavit and Authorization for Release of Information form sent to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
UA Licensure Verification form sent to the Board from each state board through which you have ever held any physician license if KSBHA is unable to verify the license.	<input type="checkbox"/>	<input type="checkbox"/>
American Medical Association or American Osteopathic Information Association report sent to the Board from the AMA or AOIA.	<input type="checkbox"/>	<input type="checkbox"/>
Fingerprint card.	<input type="checkbox"/>	<input type="checkbox"/>
Notarized copy of birth certificate or current, valid passport sent to the Board.	<input type="checkbox"/>	Completed via FCVS
Supporting documentation of any legal name change sent to the Board.	<input type="checkbox"/>	Completed via FCVS
Medical Education Verification form sent to the Board from all medical schools attended.	<input type="checkbox"/>	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school(s).	<input type="checkbox"/>	Completed via FCVS
Notarized copy/copies of medical school diploma sent to the Board.	<input type="checkbox"/>	Completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended.	<input type="checkbox"/>	Completed via FCVS
Copy of your postgraduate training certificate(s) sent to the Board.	<input type="checkbox"/>	Completed via FCVS
Fifth Pathway form (if applicable) sent to the Board from the medical school and institution - include a copy of your diploma (must be sealed by your school).	<input type="checkbox"/>	Completed via FCVS
Examination Transcripts sent to the Board.	<input type="checkbox"/>	Completed via FCVS
ECFMG Status Report (if applicable) sent to the Board.	<input type="checkbox"/>	Completed via FCVS
Notarized copy of ECFMG Certificate (if applicable) sent to the Board.	<input type="checkbox"/>	Completed via FCVS



**KANSAS LICENSURE APPLICATION ADDENDUM INSTRUCTIONS
MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)**

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Addendum

Complete each addendum as instructed. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Kansas State Board of Healing Arts at the address above.

- Addendum 1** These questions must be completed by the applicant.
- Addendum 2** Each question must be completed by the applicant. Documentation must be provided for any “yes” answer(s). **It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**
- Addendum 3** The applicant’s full name and date of birth should be printed in the spaces provided on both pages. Two (2) recommendations by licensed physicians that can attest to the applicant’s good moral character, and who have known the applicant for at least one year are required. The completed forms must be **returned directly to the Board.** Two (2) forms have been provided for your convenience.
- Addendum 4** This form must be completed by the applicant. All applicants for licensure in the State of Kansas must request a disciplinary inquiry report from the Federation of State Medical Boards (FSMB). Once this form has been completed, you may email it to the FSMB at boardinquiry@fsmb.org.
If you are using FCVS, do not complete this form. They will obtain your disciplinary report and send it to the Board.
- Addendum 5** Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. Addendum 5 explains in detail how to obtain and submit fingerprints to the Board.
Be aware that fingerprint processing may delay your application. Please make it a PRIORITY to complete the fingerprint process. Complete, sign and return the Waiver Agreement and Statement form directly to the Board.
- Credit Card Payment Authorization Form** This form should be used by applicants for payment of the Kansas application fee by credit card. Please enter the required information and return the form directly to the Board at the address above.

ADDENDUM 1

KANSAS STATE BOARD OF HEALING ARTS

Select the discipline applying for and the license designation being requested.

Medicine & Surgery Osteopathic Medicine & Surgery

Active

A license issued to a person authorizing the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Applicants for active licensure must provide evidence of professional liability insurance (which will be in effect as of the date of licensure) in compliance with Kansas law before a license will be issued. Each active license may be renewed annually. Licensees must maintain and submit evidence of satisfactory completion of a program of continuing education. Licensees must maintain and submit evidence of professional liability insurance, and contribute to the Kansas Health Care Stabilization Fund (more information about this fund can be found here: <https://hcsf.kansas.gov/>).

Federal Active

A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

Inactive

A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

Exempt

A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

List intended professional activities: _____

Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas? Yes No

2. Give location of intended practice in Kansas _____

3. Primary Specialty _____

American Board Certified _____

American Board Eligible _____

ADDENDUM 2

KANSAS STATE BOARD OF HEALING ARTS

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.****

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): _____ Date of Birth: _____

**Please mail this document to the Kansas State Board of Healing Arts at the address above.
Thank you. DO NOT RETURN TO APPLICANT.**

This is to certify that I have known Dr. _____ (type or print) for _____ years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. _____ is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: _____

Profession: Please select one: MD DO

Street 1: _____

Street 2: _____

State/Zip: _____

Telephone: _____

Signature: _____

Date: _____

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): _____ Date of Birth: _____

**Please mail this document to the Kansas State Board of Healing Arts at the address above.
Thank you. DO NOT RETURN TO APPLICANT.**

This is to certify that I have known Dr. _____ (type or print) for _____ years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. _____ is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: _____

Profession: Please select one: MD DO

Street 1: _____

Street 2: _____

State/Zip: _____

Telephone: _____

Signature: _____

Date: _____

ADDENDUM 4
KANSAS STATE BOARD OF HEALING ARTS

Applicant: Complete this form and email it to boardinquiry@fsmb.org. You must also check the box below.

I hereby certify that I am the individual referenced below and I acknowledge that I have answered all questions and reported all information on this page truthfully and completely.



Federation of State Medical Boards of the United States, Inc.

400 Fuller Wiser Road, Suite 300 | Euless, TX 76039

Tel (817) 868-4000 Fax (817) 868-4099

Physician Data Center Inquiry Form

Attention: State Board Inquiries

The Kansas State Board of Healing Arts is requesting a PDC Search concerning the following individual:

Last Name _____

First Name _____

Middle Name _____

Date of Birth _____

Daytime Phone _____

Email _____

Degree (MD, DO, or PA only) _____

Medical School _____

Year of Graduation _____

Last Four Digits of Social Security Number _____

ECFMG # (if applicable) _____

NPI Number _____

Please mail the result to the following address:

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



FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS

A criminal background check is required prior to issuance of licensure. Be aware that fingerprint processing may delay your application. **Please make it a priority to complete the fingerprint process.**

Following is the Waiver Agreement and FBI Privacy Act Statement. Please complete, sign and date the top portion of this form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Please visit <https://www.nbinformation.com/locations/locationMap.php> for a listing of fingerprinting locations.

Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the fingerprints must be printed on the fingerprint card and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email KSBHA_Licensing@ks.gov or call (785) 296-7413.

Complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submission. Include name, aliases, complete mailing address, social security number, citizenship, date of birth, and personal information (sex, race, height, weight, eyes, hair, place of birth). The spaces for OCA, FBI and MNU numbers can be left blank. Cards with missing or incomplete information will be rejected and must be resubmitted.

Mail the completed Waiver Agreement and fingerprint card to the Board. You may want to use a mailing service that allows for delivery confirmation.

Kansas State Board of Healing Arts
Attn: Licensing
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612
Phone: (785) 296-0934
Email: KSBHA_Licensing@ks.gov

Fingerprint results are valid for 6 months from the date received. Applications for licensure completed after the 6-month period will be required to submit a new Waiver Agreement, fingerprint card, and \$47 fee.

**WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT**

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) **The Kansas State Board of Healing Arts** to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. The fingerprints are authorized to be submitted under the authority of the National Childcare Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law 103-209 and Public Law 105-251. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, the Authorized Recipient may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the above-referenced Authorized Recipient of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Authorized Recipient may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities until the criminal history background check is completed.

I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose to challenge the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. (See 5 United States Code (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

FBI PRIVACY ACT STATEMENT

Authority:

The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C.534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).

Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:

Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

**WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)**

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

Routine Uses:

The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System

(Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:

The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

**RIGHT TO OBTAIN AND CHALLENGE ACCURACY
OF CRIMINAL HISTORY RECORDS**

You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness.

Alternatively, you may obtain a copy of your **Kansas criminal history record information** (CHRI) to review for accuracy and completeness, by submitting a set of your fingerprints, a letter requesting your criminal history record, and payment of the appropriate fee to the KBI. For further details, including the current fee, visit the following Internet website: http://www.kansas.gov/kbi/info/info_brochures.shtml then find the brochure named "Record Checks for Non-Criminal Justice Purposes". Or, to provide official court documents to make a correction you may write to:

Kansas Bureau of Investigation
Attn: Criminal History Records
1620 SW Tyler
Topeka, Kansas 66612-1837

If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license, certification or registration, or adoption.

To obtain a copy of your **national CHRI, also known as the Identity History Summary**, for review and challenge you must submit a set of your fingerprints and the appropriate fee to the FBI. Information regarding this process may be obtained at: <https://www.fbi.gov/services/cjis/identity-history-summary-checks>. Or, you may write to:

FBI CJIS Division
Attn: Criminal History Analysis Team 1
1000 Custer Hollow Road
Clarksburg, West Virginia 26306

**WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)**

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34). The Authorized Recipient must submit a new set of fingerprints and fee to receive the updated federal criminal history record.

I have ____ **OR** have not ____ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 5903.

The name, address, and date of birth provided below appear on a valid identification document as defined in Title 28 United States Code, section 1028.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information how to challenge my criminal records for accuracy and completeness.

Signature _____ Date _____

Printed Name _____ Date of Birth _____

Residential Address _____ City _____ State _____ Zip _____

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

Method of Verifying Identity:	<input type="checkbox"/> Driver's License	<input type="checkbox"/> State Issued ID Card
	<input type="checkbox"/> Military ID Card	
State/Branch: _____	ID Number: _____	

Agency Name: _____

Address: _____

Telephone: _____ Fax: _____

Name of Individual Verifying Identity: _____

***AUTHORIZED RECIPIENT: 1. Must maintain original or arrange for KBI to maintain.
2. Must provide a copy to the applicant.***



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			

Uniform Application – Core Application

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

Indicate your full legal name and any other names you have used in the past. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change to the Board.

Please complete all fields and indicate which address you want to use for public access and at which address you want to receive mailings from the Board. State laws vary on which address or phone number is or is not a matter of public record. Additionally, many state boards publish the Public Access address on their web sites. You may wish to contact the appropriate state licensing authority to determine which information will be a matter of public record.

If you are not using FCVS, you must submit one of the following to the Board: certified birth certificate, notarized copy of your birth certificate, original valid passport, or notarized copy of your current valid passport. Please check the state specific instructions for more information.

Be sure to list your name at the top of each following page.

Full Name

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Maiden name (if applicable): _____

All other names used/identified as: _____

_____ Degree Type M.D. D.O.

Practice Address

Public Access Street: _____

Mailings for Medical Board _____

City: _____

State/Province: _____

Zip code: _____ Country: _____

Practice phone: _____ Practice fax: _____

Alternate phone: _____ Alternate fax: _____

Practice email: _____

Home Address

Public Access Street: _____

Mailings for Medical Board _____

City: _____

State/Province: _____

Zip code: _____ Country: _____

Home phone: _____ Home fax: _____

Alternate phone: _____ Alternate fax: _____

Home email: _____

Identification

Date of birth: _____ Gender: _____ Birth city: _____
(mm/dd/yyyy)

Birth state/province: _____ Birth country: _____

Social Security number*: _____ NPI number**: _____ U.S. Citizen? Yes No
(9 digits) (10 digits)

*Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

**The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, visit <http://www.cms.hhs.gov/NationalProvIdentStand/>

Applicant Name: _____

List all medical schools you have attended, even those from which you did not graduate, in chronological order. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Medical Education Verification form and send it to all medical schools you have attended. Include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to the Board.

Additionally, the medical school must provide the Board with an official copy of your transcripts. If transcripts are not in English, an original, certified, and official English translation is required.

If you attended a Fifth Pathway program and are not using FCVS, you must complete the Fifth Pathway Verification form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical School and institution must forward all documentation directly to the Board.

If ECFMG is applicable and you are not using FCVS, contact ECFMG and have a certified status report forwarded from them to the Board. There is a separate fee for this report.

Medical School

1. Full Name of Medical School: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Attendance dates: From _____ to _____
(mm/yyyy) (mm/yyyy)
Date degree conferred/issued (indicate if not applicable): _____
(mm/dd/yyyy)
Degree received (as stated on diploma): _____
(indicate if not applicable)

2. Full Name of Medical School: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Attendance dates: From _____ to _____
(mm/yyyy) (mm/yyyy)
Date degree conferred/issued (indicate if not applicable): _____
(mm/dd/yyyy)
Degree received (as stated on diploma): _____
(indicate if not applicable)

Fifth Pathway

I did not participate in a Fifth Pathway program.

Affiliated medical school that awarded the Fifth Pathway Certification

Full Name of Medical School: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Attendance dates: From _____ to _____
(mm/yyyy) (mm/yyyy)
Date degree conferred/issued: _____ Degree (as stated on diploma): _____
(mm/dd/yyyy)

Hospital or clinic in which you performed the required rotations

Institution name: _____
Rotation dates: From _____ to _____ Certificate date: _____
(mm/yyyy) (mm/yyyy) (mm/dd/yyyy)

ECFMG

I do not have an ECFMG certificate.

Certificate number: _____ Issue date: _____
(mm/dd/yyyy)

Applicant Name: _____

List all postgraduate programs you have attended, even those you did not complete. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Postgraduate Training Verification form and send it to all postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to the Board. The postgraduate program must forward all documentation directly to the Board.

Postgraduate Training

1. Full Name of Hospital: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Department/Specialty: _____
Affiliated medical school name: _____
Attendance dates: From _____ to _____ Postgraduate year (e.g., 1, 2, 3, etc.): _____
(mm/yyyy) (mm/yyyy)
 Chief Resident Internship/Residency Residency Transitional
 Fellowship Junior Registrar Residency/Chief Residency
 Fellowship/Research Preliminary Senior House Officer Unknown
 House Officer Registrar Senior Registrar Unspecified
 Internship Research Other: _____
Successfully completed? Yes No In progress; expected completion in _____
(mm/yyyy)

2. Full Name of Hospital: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Department/Specialty: _____
Affiliated medical school name: _____
Attendance dates: From _____ to _____ Postgraduate year (e.g., 1, 2, 3, etc.): _____
(mm/yyyy) (mm/yyyy)
 Chief Resident Internship/Residency Residency Transitional
 Fellowship Junior Registrar Residency/Chief Residency
 Fellowship/Research Preliminary Senior House Officer Unknown
 House Officer Registrar Senior Registrar Unspecified
 Internship Research Other: _____
Successfully completed? Yes No In progress; expected completion in _____
(mm/yyyy)

3. Full Name of Hospital: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Department/Specialty: _____
Affiliated medical school name: _____
Attendance dates: From _____ to _____ Postgraduate year (e.g., 1, 2, 3, etc.): _____
(mm/yyyy) (mm/yyyy)
 Chief Resident Internship/Residency Residency Transitional
 Fellowship Junior Registrar Residency/Chief Residency
 Fellowship/Research Preliminary Senior House Officer Unknown
 House Officer Registrar Senior Registrar Unspecified
 Internship Research Other: _____
Successfully completed? Yes No In progress; expected completion in _____
(mm/yyyy)

Applicant Name: _____

List the information for each licensure exam you have taken, whether U.S. or international (USMLE, LMCC, NBME, etc.).

If you are not using FCVS, you must contact the appropriate examination entity and have them send a certified transcript of your scores directly to the Board.

Examination History

<u>Examination</u>	<u>Most recent date taken</u> (mm/yyyy)	<u>Passed/Failed/Unknown</u>	<u>Number of attempts</u>
FLEX Pre-1985	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
FLEX Component 1	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
FLEX Component 2	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
LMCC – Single	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
LMCC – Part I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
LMCC – Part II	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBME Part I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBME Part II	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBME Part III	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
SPEX	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBOME Part I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBOME Part II	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
NBOME Part III	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMLEX-USA Level 1	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMLEX-USA Level 2, CE	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMLEX-USA Level 2, PE	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMLEX-USA Level 3	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
COMVEX	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
USMLE Step I	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
USMLE Step II, CS	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
USMLE Step II, CK	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
USMLE Step III	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
State Board Exam			
State: _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
State: _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
State: _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____
State: _____	_____	<input type="checkbox"/> (P) <input type="checkbox"/> (F) <input type="checkbox"/> (U)	_____

List all state and Canadian provinces where you currently hold or have ever held any type of health care related license. Please copy and attach additional pages if necessary.

You must also complete the Licensure Verification form and send it to all states in which you have held any health care license or certification. Some state boards charge a fee for this information. The verifying entity must forward all licensure documentation to the Board.

State/Province Professional Licensure

1. Practitioner license type: Full license Temporary Training Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	

State/Province: _____ License number: _____ Issue date: _____

License status: Active Expired In Good Standing

Inactive Limited Probationary

Restricted Retired Revoked Suspended

Applicant Name: _____

Please copy and attach additional pages if necessary.

2. Practitioner license type: Full license Temporary Training Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	_____

State/Province: _____ License number: _____ Issue date: _____

License status: Active Expired In Good Standing
 Inactive Limited Probationary
 Restricted Retired Revoked Suspended

3. Practitioner license type: Full license Temporary Training Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	_____

State/Province: _____ License number: _____ Issue date: _____

License status: Active Expired In Good Standing
 Inactive Limited Probationary
 Restricted Retired Revoked Suspended

4. Practitioner license type: Full license Temporary Training Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	_____

State/Province: _____ License number: _____ Issue date: _____

License status: Active Expired In Good Standing
 Inactive Limited Probationary
 Restricted Retired Revoked Suspended

5. Practitioner license type: Full license Temporary Training Limited

<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Doctor of Osteopathic Medicine	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Doctor of Dental Surgery	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Doctor of Dental Medicine	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Doctor of Psychology	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Doctor of Podiatric Medicine	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Doctor of Chiropractic	_____

State/Province: _____ License number: _____ Issue date: _____

License status: Active Expired In Good Standing
 Inactive Limited Probationary
 Restricted Retired Revoked Suspended

Applicant Name: _____

List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

*Also list your permanent or home address for each non-working time.

If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.

DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS SECTION.

Copy and attach additional pages as necessary.

** Clinical indicates the percentage of time spent with patients.

*** Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

Chronology of Activities

1. Start date: _____ End date: _____
(mm/yyyy) (mm/yyyy)
Type of Activity: Health activity (non-working time due to health reasons)
 Military service Postgraduate training/education
 Seeking employment Vacation Work
Practice/Employment Name **or** Description of non-working time*: _____

Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Position: _____
Department: _____ Clinical**: ____% Administrative***: ____%
 Employment Staff Privileges Affiliation
 Other (describe your relationship with this institution): _____

2. Start date: _____ End date: _____
(mm/yyyy) (mm/yyyy)
Type of Activity: Health activity (non-working time due to health reasons)
 Military service Postgraduate training/education
 Seeking employment Vacation Work
Practice/Employment Name **or** Description of non-working time*: _____

Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Position: _____
Department: _____ Clinical**: ____% Administrative***: ____%
 Employment Staff Privileges Affiliation
 Other (describe your relationship with this institution): _____

3. Start date: _____ End date: _____
(mm/yyyy) (mm/yyyy)
Type of Activity: Health activity (non-working time due to health reasons)
 Military service Postgraduate training/education
 Seeking employment Vacation Work
Practice/Employment Name **or** Description of non-working time*: _____

Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Position: _____
Department: _____ Clinical**: ____% Administrative***: ____%
 Employment Staff Privileges Affiliation
 Other (describe your relationship with this institution): _____

Applicant Name: _____

Copy and attach additional pages as necessary.

4. Start date: _____ End date: _____
(mm/yyyy) (mm/yyyy)

Type of Activity: Health activity (non-working time due to health reasons)
 Military service Postgraduate training/education
 Seeking employment Vacation Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

Employment Staff Privileges Affiliation
 Other (describe your relationship with this institution): _____

5. Start date: _____ End date: _____
(mm/yyyy) (mm/yyyy)

Type of Activity: Health activity (non-working time due to health reasons)
 Military service Postgraduate training/education
 Seeking employment Vacation Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

Employment Staff Privileges Affiliation
 Other (describe your relationship with this institution): _____

6. Start date: _____ End date: _____
(mm/yyyy) (mm/yyyy)

Type of Activity: Health activity (non-working time due to health reasons)
 Military service Postgraduate training/education
 Seeking employment Vacation Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

Employment Staff Privileges Affiliation
 Other (describe your relationship with this institution): _____

Please copy and attach additional pages as necessary.

Applicant Name: _____

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

I have not had any malpractice claims or suits made against me.

1. Name of patient involved: _____
In which state, territory, or province did the action take place? _____
Which court*? _____
Case number (if applicable) _____ Month and year of lawsuit: _____
Month and year of event precipitating claim: _____
Current claim status: Closed (settled) Dismissed (no money paid out)
 Open (pending) Other: _____
Amount of judgment or settlement: \$ _____ Amount paid on your behalf: \$ _____
What is/was your status? Primary Defendant Co-Defendant
 Other (specify): _____
Insurance carrier at the time: _____

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

Complete the forms on the following pages as instructed.

- UA Affidavit and Authorization for Release of Information
- UA Form #1: Licensure Verification Form
- All state-specific forms included with this core application

If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

- UA Form #2: Medical School Verification
- UA Form #3: Postgraduate Training Verification
- UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.



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: _____



Licensure Verification (UA Form #1)

Applicant: Complete this form as instructed in the left sidebar.

Licensing Board: Send this completed form to the address listed in Section 1.

Applicant:

This form must be used for licensure verification of each full, temporary, training, or limited license you have held. This form must be completed even if you are using FCVS.

Send this form and any verification fee to each state board you hold a license with. Copy this form for multiple licenses.

Section 1: Applicant Information

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Date of birth: _____ Social Security number*: _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization: I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to license number _____ to the following Board:

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: _____ **Date:** _____

Licensing Board:

Please complete Section 2 of this form and send it to the Kansas State Board of Healing Arts at the address listed in Section 1.

Alternatively, provide electronic verification of licensure to the Kansas State Board of Healing Arts.

Section 2: Licensure Verification

Name of Licensee: _____
Last First Middle Suffix

Issuing State Board: _____ License type: _____

License number: _____ Issue date: _____ Expiration date: _____

Is this license current? Yes No If not current, please explain: _____

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? Yes No Cannot answer under state law

If yes, please explain: _____

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state?

Yes No Cannot answer under state law

If yes, please explain: _____

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX BOARD SEAL HERE

(If no seal is available, this form must be notarized.)

Signature: _____

Print name: _____

Title: _____

Date: _____

Email: _____



Medical School Verification (UA Form #2)

Applicant: Complete this form as instructed in the left sidebar.

Dean or Designated Med School Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

Section 1: Applicant Information

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Name if different when diploma awarded: _____

Name of medical school: _____

Date of birth: _____ Social Security number*: _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts

Mailing address: 800 SW Jackson, Lower Level – Suite A

City/State/Zip: Topeka, KS 66612

Applicant signature: _____ Date: _____

Dean or Designated Official:

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the Kansas State Board of Healing Arts at the address listed in Section 1. **Do not mail this form to FCVS/FSMB.**

If transcripts are not in English, an original, certified, and official English translation is required.

Section 2: Medical School Verification

Medical school name: _____

School name if different when the above applicant attended: _____

Medical school address (including city, state or province, zip code, and country as applicable):

Hours of undergraduate education required for admission into your school: _____

Total weeks of education applicant attended your school: _____

Applicant's attendance dates: From _____ to _____

Graduation date: _____ Degree: _____
(indicate N/A if not applicable) (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

Applicant Name: _____

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes No

If yes, please select the reason(s), indicate the dates of the interruption(s) or extension(s), and indicate whether the interruption(s)/extension(s) was/were approved or unapproved.

	From Month/Year	To Month/Year	Approved	Unapproved
<input type="checkbox"/> Personal/Family	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Academic remediation	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Health	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Financial	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in joint degree program (e.g., MD/PhD)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in non-research special study (e.g., fellowship, international experience)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes No

If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
<input type="checkbox"/> Academic probation	_____	_____
<input type="checkbox"/> Probation for unprofessional conduct/behavioral reasons	_____	_____
<input type="checkbox"/> Probation for other reason(s) (please specify):	_____	_____

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes No

If yes, please attach documentation/information of the circumstances and outcome(s).

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Yes No

If yes, please attach documentation/information of the circumstances and outcome(s).

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes No

If yes, please attach documentation/information of the nature of the limitations or special requirements.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

Title: _____

Date: _____

Phone number: _____ Fax number: _____

Email: _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)



Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.

Program Director or Designated Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

Section 1: Applicant Information

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Name if different when diploma awarded: _____

Name of postgraduate training program: _____

Date of birth: _____ Social Security number*: _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: _____ **Date:** _____

Dean or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

Section 2: Postgraduate Training Verification

Institution name: _____

Institution address: _____

Institution city / state or province / zip code: _____

Affiliated medical school name: _____

Institution / school name if different when the applicant attended: _____

Postgraduate year (e.g., 1, 2, 3, etc.): _____ Internship Residency Fellowship

Research Chief Residency Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? Yes No In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ACGME AOA LCGME RSC CFPC
 RCPSC APPAP None of these

Applicant Name: _____

Postgraduate year (e.g., 1, 2, 3, etc.): _____ Internship Residency Fellowship
 Research Chief Residency Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? Yes No In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ACGME AOA LCGME RSC CFPC
 RCPSC APPAP None of these

Postgraduate year (e.g., 1, 2, 3, etc.): _____ Internship Residency Fellowship
 Research Chief Residency Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? Yes No In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ACGME AOA LCGME RSC CFPC
 RCPSC APPAP None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

- 1. Did this individual ever take a leave of absence or break from his/her training? Yes No
- 2. Was this individual ever placed on probation? Yes No
- 3. Was this individual ever disciplined or placed under investigation? Yes No
- 4. Were any negative reports for behavioral reasons ever filed by instructors? Yes No
- 5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes No

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

Title: _____

Date: _____

Phone number: _____ Fax number: _____

Email: _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)



Fifth Pathway Verification (UA Form #4)

Applicant: Complete this form as instructed in the left sidebar.

Program Director or Designated Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to your Fifth Pathway director.

Section 1: Applicant Information

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Name if different when certificate awarded: _____

Name of medical school: _____

Date of birth: _____ Social Security number*: _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I authorize the Program Director or designated official of the Fifth Pathway program to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: _____ **Date:** _____

Program Director or Designated Official:

Please complete all of Section 2. Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

Section 2: Fifth Pathway Verification

Institution name: _____

Institution address: _____

Institution city / state or province / zip code: _____

Institution / school name if different when the applicant attended: _____

Enrollment dates: From _____ to _____

Completed? Yes. Certification date: _____
 No. Withdrawal date: _____
 No. Dismissal date: _____
 In progress. Expected completion date: _____

If the applicant withdrew or was dismissed, please explain in the space below. Attach additional information if needed.

Applicant Name: _____

Type of Clinical Rotation	From	To	Number of Weeks Credit
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Unusual Circumstances

- 1. Did this individual ever take a leave of absence or break from his/her training? Yes No
- 2. Was this individual ever placed on probation? Yes No
- 3. Was this individual ever disciplined or placed under investigation? Yes No
- 4. Were any negative reports for behavioral reasons ever filed by instructors? Yes No
- 5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes No

Please explain any "Yes" response in the blank space below. Attach additional information if needed.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

Title: _____

Date: _____

Phone number: _____ Fax number: _____

Email: _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)