



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 June 30 and are renewed annually. License renewal will be required of all MD applicants receiving permanent licenses prior to April 1. DO licenses expire on September 30 and are renewed annually. License renewal will be required of all DO applicants receiving permanent licenses prior to July 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 engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

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 and Statement of Health:

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 _____

4. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your particular branch of the healing arts or your particular specialty? Yes No

If yes, applicant shall file with this application a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

ADDENDUM 2

KANSAS STATE BOARD OF HEALING ARTS

Please answer each of the following questions by putting a check (✓) in the appropriate box. All “yes” answers MUST be thoroughly explained in detail in 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 that 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 particular question, check (✓) the “yes” box and submit the appropriate form if required. 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, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check (✓) the “no” box. It is your continuing duty to update the Board on any changes once the application has been submitted.

1. Yes No 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 or educational program, including but not limited to medical school, prior to completing the training?
2. Yes No Have you ever had any application for any professional license refused or denied by any licensing authority?
3. Yes No Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?
4. Yes No 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?
5. Yes No Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?
6. Yes No 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?
7. Yes No Have you ever voluntarily surrendered any professional license?
8. Yes No 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?
9. Yes No Have you ever been notified or requested to appear before a licensing or disciplinary agency?
10. Yes No 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?

11. Yes No Has any professional association imposed any disciplinary action against you?
12. Yes No Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?
13. Yes No Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?
14. Yes No Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?
15. Yes No Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?
16. Yes No Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?
17. Yes No 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?
18. Yes No Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?
19. Yes No Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?
20. Yes No 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.
21. Yes No 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.
22. Yes No Have you ever been court-martialed or discharged dishonorably from the armed services?
23. Yes No 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?
24. Yes No Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?
25. Yes No Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company?

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: _____

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: _____

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

ADDENDUM 5



INSTRUCTIONS FOR REQUESTING A CRIMINAL BACKGROUND CHECK

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.

Following is the *Waiver Agreement and Statement*. Please complete, sign and date the *Waiver Agreement and Statement* form with your application. Your application will not be deemed as complete without a completed and signed *Waiver Agreement and Statement* form.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. Your local law enforcement agency should be willing to assist you with completing the fingerprints. Some enforcement agencies offer electronic scanning (Livescan). Please visit our website at www.ksbha.org for a listing of Livescan agencies. Have at least one form of picture identification for the law enforcement agency to examine.

If you do not utilize a Livescan agency, contact the Board at 785-296-7413 or 888-886-7205 to receive a fingerprint card, or visit <http://www.fbi.gov/about-us/cjis/identity-history-summary-checks/fd-258-1> to print a fingerprint card. If printing the card, please print on card stock paper.

Please complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submitting the fingerprint card. Be sure to include name (including aliases, maiden and previous names), 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. Sign the card in front of the law enforcement officer. If you use Livescan, the agency may have a different form for you to complete.

Make a check or money order (do not send cash) payable to the Kansas State Board of Healing Arts for \$47. A fingerprint card submitted without payment will not be processed.

Provide the law enforcement officer with a stamped envelope addressed to: KSBHA, 800 SW Jackson, LL- Suite A, Topeka, KS 66612 to mail your fingerprint card or electronic scan, and fee. In addition, you may want to use a mailing service that allows for delivery confirmation to confirm your fingerprint card and payment have been received at the Board. Bent and folded cards will not be accepted and a new fingerprint card will be mailed to you for prints to be taken again.

A background check is valid for six (6) months. Application for licensure completed after the six (6) month period will be required to submit a new fingerprint card for a new clearance.

Any and all resubmissions of fingerprint cards require a \$47 submission fee to process. Resubmitted fingerprint cards will not be processed without payment.

Please complete, sign and date the *Waiver Agreement and Statement* form with your application. Your application will not be deemed as complete without a completed and signed *Waiver Agreement and Statement* form.

800 SW Jackson, Lower Level, Suite A, TOPEKA, KS 66612
Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

revised 2-12-15, kl

ADDENDUM 5



**WAIVER AGREEMENT AND STATEMENT
Fingerprint-Based Record Checks for Noncriminal Justice Purposes**

I hereby authorize 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. Pursuant to K.S.A. 22-4701 *et seq.* and K.S.A. 22-5001, the Kansas State Board of Healing Arts may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the Kansas State Board of Healing Arts of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Kansas State Board of Healing Arts may choose to deny my application or grant me a limited or restricted license until the criminal history background check is completed.

I understand that, upon my request, the Kansas State Board of Healing Arts will provide me with a summary of the information contained in my Criminal History Background Report for the limited purpose of challenging the accuracy and/or completeness of the information contained in the report, but will not provide me with a complete copy of the Criminal History Background Report. I understand that I may obtain a prompt determination as to the validity of my challenge before the Kansas State Board of Healing Arts makes a final decision about my application for license to practice the healing arts. I further understand that I will not be provided access to information in my Criminal History Background Report under the following circumstances: 1) I am granted a full, unrestricted license, 2) I voluntarily withdraw an application for licensure, or 3) I am denied a license and have exhausted all my right to appeal the denial.

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 3805, and may result in the denial of my application pursuant to K.S.A. 65-2836 (a).

Signature

Date

Printed Name

Date of Birth

Residential Address City State Zip

800 SW Jackson, Lower Level, Suite A, TOPEKA, KS 66612
Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

revised 9-8-11, kl

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)

<input type="checkbox"/> Chief Resident	<input type="checkbox"/> Internship/Residency	<input type="checkbox"/> Residency	<input type="checkbox"/> Transitional
<input type="checkbox"/> Fellowship	<input type="checkbox"/> Junior Registrar	<input type="checkbox"/> Residency/Chief Residency	
<input type="checkbox"/> Fellowship/Research	<input type="checkbox"/> Preliminary	<input type="checkbox"/> Senior House Officer	<input type="checkbox"/> Unknown
<input type="checkbox"/> House Officer	<input type="checkbox"/> Registrar	<input type="checkbox"/> Senior Registrar	<input type="checkbox"/> Unspecified
<input type="checkbox"/> Internship	<input type="checkbox"/> Research	<input type="checkbox"/> 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)

<input type="checkbox"/> Chief Resident	<input type="checkbox"/> Internship/Residency	<input type="checkbox"/> Residency	<input type="checkbox"/> Transitional
<input type="checkbox"/> Fellowship	<input type="checkbox"/> Junior Registrar	<input type="checkbox"/> Residency/Chief Residency	
<input type="checkbox"/> Fellowship/Research	<input type="checkbox"/> Preliminary	<input type="checkbox"/> Senior House Officer	<input type="checkbox"/> Unknown
<input type="checkbox"/> House Officer	<input type="checkbox"/> Registrar	<input type="checkbox"/> Senior Registrar	<input type="checkbox"/> Unspecified
<input type="checkbox"/> Internship	<input type="checkbox"/> Research	<input type="checkbox"/> 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)

<input type="checkbox"/> Chief Resident	<input type="checkbox"/> Internship/Residency	<input type="checkbox"/> Residency	<input type="checkbox"/> Transitional
<input type="checkbox"/> Fellowship	<input type="checkbox"/> Junior Registrar	<input type="checkbox"/> Residency/Chief Residency	
<input type="checkbox"/> Fellowship/Research	<input type="checkbox"/> Preliminary	<input type="checkbox"/> Senior House Officer	<input type="checkbox"/> Unknown
<input type="checkbox"/> House Officer	<input type="checkbox"/> Registrar	<input type="checkbox"/> Senior Registrar	<input type="checkbox"/> Unspecified
<input type="checkbox"/> Internship	<input type="checkbox"/> Research	<input type="checkbox"/> 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: _____



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: _____

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(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: _____

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(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.)