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/](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](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/](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](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 May 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 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.

<table>
<thead>
<tr>
<th>Completed Uniform Application (UA).</th>
<th>NOT using FCVS to verify credentials</th>
<th>Using FCVS to verify credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed state addenda and fees (licensure fee of $300 plus National Practitioner Data Bank Report fee of $3) sent to the Board.</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Notarized UA Affidavit and Authorization for Release of Information form sent to the Board.</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>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.</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>American Medical Association or American Osteopathic Information Association report sent to the Board from the AMA or AOIA.</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Fingerprint card.</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Notarized copy of birth certificate or current, valid passport sent to the Board.</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Supporting documentation of any legal name change sent to the Board.</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Medical Education Verification form sent to the Board from all medical schools attended.</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Medical School Transcripts sent to the Board by your medical school(s).</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Notarized copy/copies of medical school diploma sent to the Board.</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Postgraduate Training Verification form sent to the Board from all programs you attended.</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Copy of your postgraduate training certificate(s) sent to the Board.</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>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).</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Examination Transcripts sent to the Board.</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>ECFMG Status Report (if applicable) sent to the Board.</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Notarized copy of ECFMG Certificate (if applicable) sent to the Board.</td>
<td>□</td>
<td>Completed via FCVS</td>
</tr>
</tbody>
</table>
KANSAS LICENSURE APPLICATION ADDENDUM INSTRUCTIONS
MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)

Please visit [www.ksbha.org](http://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.
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 DUL, 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?
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: ___________________________________________________________________

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

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: ________________________________________________________________________________

Please mail this document to the Kansas State Board of Healing Arts at the address above.
Thank you. DO NOT RETURN TO APPLICANT.
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
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 FBI Privacy Act Statement. Please complete, sign and date the Waiver Agreement and FBI Privacy Act Statement form with your application. Your application will not be deemed as completed 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 http://www.ksbha.org/departments/licensing/licensingdept.shtml 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 https://www.fbi.gov/file-repository/standard-fingerprint-form-fd-258-1.pdf/view 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 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 fingerprints cards require a $47 as of February 1, 2015 to process. Resubmitted fingerprint cards will not be processed without payment.

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

revised 5/4/18 bv
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. 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)

revised 5-4-18 bv
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
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.

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: Driver's License □ State Issued ID Card □
State/Branch: Military ID Card □ 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 CARD PAYMENT AUTHORIZATION FORM

Please print or type.

CARD NUMBER

[Redacted]

Verification Code
3-digit non-embossed number found on the card signature panel

Expiration Date
MO VR

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)

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

Revised 12-18-07 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

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: ______________________ (mm/dd/yyyy)  Gender: _____  Birth city:______________________________
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/

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.
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.

Applicant Name:

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)
### Postgraduate Training

1. **Full Name of Hospital:**

   Street:

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

   **Affiliated medical school name:**

   **Attendance dates:** From (mm/yyyy) to (mm/yyyy)  
   **Postgraduate year (e.g., 1, 2, 3, etc.): _____**

   - [ ] Chief Resident  
   - [ ] Fellowship  
   - [ ] Fellowship/Research  
   - [ ] House Officer  
   - [ ] Internship

   - [ ] Internship/Residency  
   - [ ] Junior Registrar  
   - [ ] Preliminary  
   - [ ] Registrar  
   - [ ] Research  

   - [ ] Residency  
   - [ ] Residency/Chief Residency  
   - [ ] Senior House Officer  
   - [ ] Senior Registrar  
   - [ ] Other: ___________________________

   - [ ] Transitional  
   - [ ] Unknown  
   - [ ] Unspecified

   Successfully completed? [ ] Yes  [ ] No  [ ] In progress; expected completion in (mm/yyyy)

2. **Full Name of Hospital:**

   Street:

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

   **Affiliated medical school name:**

   **Attendance dates:** From (mm/yyyy) to (mm/yyyy)  
   **Postgraduate year (e.g., 1, 2, 3, etc.): _____**

   - [ ] Chief Resident  
   - [ ] Fellowship  
   - [ ] Fellowship/Research  
   - [ ] House Officer  
   - [ ] Internship

   - [ ] Internship/Residency  
   - [ ] Junior Registrar  
   - [ ] Preliminary  
   - [ ] Registrar  
   - [ ] Research  

   - [ ] Residency  
   - [ ] Residency/Chief Residency  
   - [ ] Senior House Officer  
   - [ ] Senior Registrar  
   - [ ] Other: ___________________________

   - [ ] Transitional  
   - [ ] Unknown  
   - [ ] Unspecified

   Successfully completed? [ ] Yes  [ ] No  [ ] In progress; expected completion in (mm/yyyy)

3. **Full Name of Hospital:**

   Street:

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

   **Affiliated medical school name:**

   **Attendance dates:** From (mm/yyyy) to (mm/yyyy)  
   **Postgraduate year (e.g., 1, 2, 3, etc.): _____**

   - [ ] Chief Resident  
   - [ ] Fellowship  
   - [ ] Fellowship/Research  
   - [ ] House Officer  
   - [ ] Internship

   - [ ] Internship/Residency  
   - [ ] Junior Registrar  
   - [ ] Preliminary  
   - [ ] Registrar  
   - [ ] Research  

   - [ ] Residency  
   - [ ] Residency/Chief Residency  
   - [ ] Senior House Officer  
   - [ ] Senior Registrar  
   - [ ] Other: ___________________________

   - [ ] Transitional  
   - [ ] Unknown  
   - [ ] Unspecified

   Successfully completed? [ ] Yes  [ ] No  [ ] In progress; expected completion in (mm/yyyy)

---

Applicant: Send this to the Kansas State Board of Healing Arts. Include all fees and required forms.

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Uniform Application for Physician State Licensure
Core Uniform Application - Page 3 of 8
Applicant Name: ________________________________________________________

Examination History

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<th>Examination</th>
<th>Most recent date taken (mm/yyyy)</th>
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</table>

State/Province Professional Licensure

1. Practitioner license type: □ Full license □ Temporary □ Training □ Limited
   □ Doctor of Medicine □ Nurse Practitioner
   □ Doctor of Osteopathic Medicine □ Licensed Practical Nurse
   □ Doctor of Dental Surgery □ Registered Nurse
   □ Doctor of Dental Medicine □ Physician Assistant
   □ Doctor of Psychology □ Emergency Medical Technician
   □ Doctor of Podiatric Medicine □ Other (please specify) ______________________
   □ Doctor of Chiropractic

State/Province: __________________ License number: __________ Issue date: __________

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

List the information for each licensure exam you have taken, whether U.S. or international (USMLE, LLMCC, 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.

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.

Applicant: Send this to the Kansas State Board of Healing Arts. Include all fees and required forms.

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Uniform Application for Physician State Licensure
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<table>
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<td></td>
<td>Doctor of Chiropractic</td>
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</tbody>
</table>

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

4. Practitioner license type: [ ] Full license [ ] Temporary [ ] Training [ ] Limited

5. Practitioner license type: [ ] Full license [ ] Temporary [ ] Training [ ] Limited

Applicant Name: ____________________________

Please copy and attach additional pages if necessary.
### 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): _______________________________  

*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.

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

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

---

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.

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

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

---

**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.**

** copied and attached 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.
Applicant Name: _____________________________

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:

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)

Notary

State of __________________________________________, County of __________________________________________.

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant’s signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this ______ day of _________________, 20____.

Notary Public Signature: ________________________________

My Notary Commission Expires: ____________________________

(NOTARY PUBLIC SEAL)
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: ________________

Section 2: Licensure Verification

Name of Licensee: ______________________________________________________________________

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.

Signature: __________________________
Print name: __________________________
Title: __________________________
Date: __________________________
Email: __________________________
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

<table>
<thead>
<tr>
<th>Last name:</th>
<th>Suffix:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name:</td>
<td></td>
</tr>
<tr>
<td>Middle name:</td>
<td></td>
</tr>
<tr>
<td>Name if different when diploma awarded:</td>
<td></td>
</tr>
<tr>
<td>Name of medical school:</td>
<td></td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Social Security number*:</td>
</tr>
</tbody>
</table>

*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: _______________

Section 2: Medical School Verification

<table>
<thead>
<tr>
<th>Medical school name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School name if different when the above applicant attended:</td>
</tr>
<tr>
<td>Medical school address (including city, state or province, zip code, and country as applicable):</td>
</tr>
<tr>
<td>Hours of undergraduate education required for admission into your school:</td>
</tr>
<tr>
<td>Total weeks of education applicant attended your school:</td>
</tr>
<tr>
<td>Applicant’s attendance dates: From __________________________ to _________________________</td>
</tr>
<tr>
<td>Graduation date: __________________________ Degree: __________________________</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>From Month/Year</th>
<th>To Month/Year</th>
<th>Approved</th>
<th>Unapproved</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Personal/Family</td>
<td>_____________</td>
<td>_____________</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Academic remediation</td>
<td>_____________</td>
<td>_____________</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Health</td>
<td>_____________</td>
<td>_____________</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Financial</td>
<td>_____________</td>
<td>_____________</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Participation in joint degree program (e.g., MD/PhD)</td>
<td>_____________</td>
<td>_____________</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Participation in non-research special study (e.g., fellowship, international experience)</td>
<td>_____________</td>
<td>_____________</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Other: ________________</td>
<td>_____________</td>
<td>_____________</td>
<td>☐</td>
</tr>
</tbody>
</table>

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).

<table>
<thead>
<tr>
<th>From Month/Year</th>
<th>To Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Academic probation</td>
<td>_____________</td>
</tr>
<tr>
<td>☐ Probation for unprofessional conduct/behavioral reasons</td>
<td>_____________</td>
</tr>
<tr>
<td>☐ Probation for other reason(s) (please specify):</td>
<td>_____________</td>
</tr>
</tbody>
</table>

__________________________________________________________________________________________________________________________________________

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: ______________________________________________

AFFIX INSTITUTIONAL SEAL HERE
Title: ____________________________________________________

(If no seal is available, this form must be notarized.)
Date: ____________________________________________________
Phone number: __________________ Fax number: ______________
Email: ____________________________________________________
**Section 1: Applicant Information**

<table>
<thead>
<tr>
<th>Last name:</th>
<th>____________________________</th>
<th>Suffix: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name:</td>
<td>__________________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Middle name:</td>
<td>__________________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Name if different when diploma awarded:</td>
<td>__________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Name of postgraduate training program:</td>
<td>_____________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Date of birth:</td>
<td>_______________________</td>
<td>Social Security number*:</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>Board name:</th>
<th>Kansas State Board of Healing Arts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing address:</td>
<td>800 SW Jackson, Lower Level – Suite A</td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Topeka, KS 66612</td>
</tr>
</tbody>
</table>

Applicant signature: __________________________________________ Date: ________________

**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?

<table>
<thead>
<tr>
<th>Accredited by:</th>
<th>ACGME</th>
<th>AOA</th>
<th>LCGME</th>
<th>RSC</th>
<th>CFPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCPSC</td>
<td>APPAP</td>
<td>None of these</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

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: __________________________________________

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

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.

---

#### Section 1: Applicant Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name</td>
<td>______________________________________________________________</td>
</tr>
<tr>
<td>Suffix:</td>
<td>________</td>
</tr>
<tr>
<td>First name</td>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td>Middle name</td>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td>Name if different when certificate awarded</td>
<td>__________________________________________________</td>
</tr>
<tr>
<td>Name of medical school</td>
<td>_______________________________________________________________</td>
</tr>
<tr>
<td>Date of birth</td>
<td>_______________________</td>
</tr>
<tr>
<td>Social Security number*:</td>
<td>_____________________________</td>
</tr>
</tbody>
</table>

*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:** ______________________

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#### Section 2: Fifth Pathway Verification

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
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<tbody>
<tr>
<td>Institution name</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>Institution address</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>Institution city / state or province / zip code</td>
<td>__________________________________________________</td>
</tr>
<tr>
<td>Institution / school name if different when the applicant attended</td>
<td>____________________________________</td>
</tr>
<tr>
<td>Enrollment dates: From</td>
<td>________________________________ to ________________________________</td>
</tr>
<tr>
<td>Completed?</td>
<td>□ Yes. Certification date: __________</td>
</tr>
<tr>
<td></td>
<td>□ No. Withdrawal date: __________</td>
</tr>
<tr>
<td></td>
<td>□ No. Dismissal date: __________</td>
</tr>
<tr>
<td></td>
<td>□ In progress. Expected completion date: __________</td>
</tr>
</tbody>
</table>

If the applicant withdrew or was dismissed, please explain in the space below. Attach additional information if needed.
<table>
<thead>
<tr>
<th>Type of Clinical Rotation</th>
<th>From</th>
<th>To</th>
<th>Number of Weeks Credit</th>
</tr>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

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: _______________________________

AFFIX INSTITUTIONAL SEAL HERE  
(If no seal is available, this form must be notarized.)

Title: ________________________________
Date: ________________________________
Phone number: ____________________  Fax number: ____________________
Email: ________________________________