



**6. Healthcare Employment/Professional History:** In chronological order, list all healthcare employment/professional history since the cancelation of your Kansas License. Attach additional page if necessary. Include actual work address, not corporate headquarters.

Activity: \_\_\_\_\_ Employer (if applicable) \_\_\_\_\_

Location: \_\_\_\_\_ Dates: From \_\_\_\_\_ To \_\_\_\_\_  
city state mm/yy mm/yy

Activity: \_\_\_\_\_ Employer (if applicable) \_\_\_\_\_

Location: \_\_\_\_\_ Dates: From \_\_\_\_\_ To \_\_\_\_\_  
city state mm/yy mm/yy

Activity: \_\_\_\_\_ Employer (if applicable) \_\_\_\_\_

Location: \_\_\_\_\_ Dates: From \_\_\_\_\_ To \_\_\_\_\_  
city state mm/yy mm/yy

Activity: \_\_\_\_\_ Employer (if applicable) \_\_\_\_\_

Location: \_\_\_\_\_ Dates: From \_\_\_\_\_ To \_\_\_\_\_  
city state mm/yy mm/yy

**7. List all states or jurisdictions in which you are currently or have ever been licensed, registered or certified as an OT/OTA. Attach an additional sheet if necessary. KSBHA will verify your credentials except for any state that does not provide free and current verifications on their official state website. For those states, you may complete the attached *Licensure Verification* form and forward to all Boards or similar entities in which you have held an OT/OTA license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.**

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

**8. Continuing Education.**

Include proof of completion of continuing education as required by K.A.R. 100-54-8, if applicable.

**Application fee of \$80. NPDB report fee of \$3. Make the fees payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.**

Applicant name: \_\_\_\_\_  
(please print or type)



## EXPEDITED LICENSURE QUESTIONNAIRE

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To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406<sup>i</sup>, please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military/law enforcement agencies.

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1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes \_\_\_ No \_\_\_ If yes:

Branch: \_\_\_\_\_ Dates of Service: \_\_\_\_\_ Military ID#: \_\_\_\_\_

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes \_\_\_ No \_\_\_ If yes:

Branch: \_\_\_\_\_ Dates of Service: \_\_\_\_\_ Military ID#: \_\_\_\_\_

3. Do you currently reside in Kansas? Yes \_\_\_ No \_\_\_ If yes:

Current Kansas Residence Address: \_\_\_\_\_

4. If you do not currently reside in Kansas, do you intend\* to establish residency in Kansas within the next 6 months?  
*\*If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military agencies in other jurisdictions.* Yes \_\_\_ No \_\_\_ If yes:

Intended Kansas Residence Address: \_\_\_\_\_

Expected Date of Commencing Residence: \_\_\_\_\_

**If you answered "no" to all questions #1 through #4, you do not need to answer questions #5 through #7.**

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. *This does not include certifications or registrations issued by private boards, professional societies, or any organization other than a government body of a state, district, or territory of the U.S.* Yes \_\_\_ No \_\_\_ If no:

- a. Have you practiced the profession for which you are seeking licensure in Kansas for at least 3 years in a state that does not license/register/certify the profession? Yes \_\_\_ No \_\_\_

- b. Have you practiced the profession for which you are seeking licensure in Kansas for at least 2 years in a state that does not license/register/certify the profession and you held a certification or registration issued by a private organization during those 2 years? Yes \_\_\_ No \_\_\_ If yes:

Organization that issued private certification/registration: \_\_\_\_\_ Date Issued: \_\_\_\_\_



\* “Active practice” does not include care provided while in a training program, residency, or fellowship; or employment that consisted solely of research activities or administrative duties. The Board generally considers active practice to be direct patient care that for either (1) at least one full day per week for 50 weeks during a year; or (2) 400 hours during a year.

6. Have you actively practiced\* the profession for which you are seeking licensure in Kansas during the last 2 years?  
Yes\_\_ No\_\_

**If you answered “yes” to question #6, you do not need to answer question #7.**

7. If you answered “No” to questions #6, please provide a detailed explanation regarding your active clinical practice and direct patient care during the 12 months immediately preceding the submission of your application. Please explain any gaps in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

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<sup>i</sup> An applicant who has not been in the active practice of their occupation during the two years preceding the application for which a license is sought, may be required to complete additional testing, training, monitoring or continuing education as the KSBHA deems necessary to establish present ability to practice in a manner that protects the health and safety of the public K.S.A. 48-3406(d).



**AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION**

**Applicant:** in the presence of a notary public, sign and date this form with attached photo.  
Email to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail it directly to the Kansas State Board of Healing Arts.

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 application for Occupational Therapist and Occupational Therapy Assistant 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 Occupational Therapy 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 Occupational Therapy.



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

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

\_\_\_\_\_  
*Date of signature (must correspond to date of notarization)*

[Please note: The notary must be clearly visible when submitting electronically]

**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 \_\_\_\_\_



## ATTESTATION QUESTIONS

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Please answer each of the following questions. **All “yes” answers MUST be thoroughly explained in detail on a separate signed page.** You are required to furnish complete details including date, place, reason, and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. **It is imperative you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

If you are unsure of your response to a question, check the “yes” box and submit the appropriate documentation. Your responses on your application are evaluated as evidence of your candor and honesty. An honest “yes” answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest “no” answer is evidence of a lack of candor and honesty. Please be advised that a false response to any of these questions may be grounds for denial of licensure. If a question is not applicable, then check the “no” box.

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Full Name of Applicant

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Date

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training? Yes \_\_\_ No \_\_\_
2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes \_\_\_ No \_\_\_
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes \_\_\_ No \_\_\_
4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges? Yes \_\_\_ No \_\_\_
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility? Yes \_\_\_ No \_\_\_
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private? Yes \_\_\_ No \_\_\_
7. Have you ever voluntarily surrendered any professional license? Yes \_\_\_ No \_\_\_
8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held? Yes \_\_\_ No \_\_\_
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes \_\_\_ No \_\_\_
10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes \_\_\_ No \_\_\_



11. Has any professional association imposed any disciplinary action against you? Yes \_\_\_ No \_\_\_
12. Do you have any physical or mental health condition (including alcohol or substance use) that currently impairs your ability to practice your profession in a competent, ethical, and professional manner? Yes \_\_\_ No \_\_\_
13. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances? Yes \_\_\_ No \_\_\_
14. Have you ever surrendered your state or federal controlled substances registration, or had it revoked, suspended, or restricted in any way? Yes \_\_\_ No \_\_\_
15. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency? Yes \_\_\_ No \_\_\_
16. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes \_\_\_ No \_\_\_
17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes \_\_\_ No \_\_\_
18. Have you ever been court martialled or discharged dishonorably from the armed services? Yes \_\_\_ No \_\_\_
19. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself? Yes \_\_\_ No \_\_\_
20. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company? Yes \_\_\_ No \_\_\_
21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company? Yes \_\_\_ No \_\_\_

***\*It is your continued duty to update the Board on any changes once the application has been submitted.\****



## LICENSE VERIFICATION FORM

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Send to all states or jurisdictions in which you currently, or have ever, held a license, permit, or certification, permanent or temporary. Verification fees may be applicable and are the applicant's responsibility. Please contact individual boards to confirm fees. The applicant should complete the top section. The official state board should complete the bottom section and email to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail it directly to the Kansas State Board of Healing Arts.

I, hereby authorize and request the state Board of \_\_\_\_\_ having control of any documents, records, and other information pertaining to me to furnish to the Kansas State Board of Healing Arts information including documents and/or records regarding charges or complaints filed against me or my license/registration; informal, pending, closed or any other pertinent information.

Full Name: \_\_\_\_\_

Other Names Used (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

License or Registration No.: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Profession: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Full Name of Licensee or Registrant: \_\_\_\_\_

License or Registration No.: \_\_\_\_\_ Status: \_\_\_\_\_

Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

License Method: \_\_\_\_\_ School: \_\_\_\_\_

### DISCIPLINARY ACTIONS:

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? Yes \_\_\_ No \_\_\_ Unable to Divulge \_\_\_

Have formal disciplinary proceedings been initiated against the applicant or applicant's license or registration by a disciplinary authority in your state? Yes \_\_\_ No \_\_\_ Unable to Divulge \_\_\_

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ (SEAL)

Title: \_\_\_\_\_

State Board of: \_\_\_\_\_

Date: \_\_\_\_\_



### THIRD PARTY RELEASE

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If you would like the Kansas State Board of Healing Arts (“Board”) staff to talk with third parties about your application complete this form. This form provides authorization for the Board to release information regarding your application to third parties. This information includes, but is not limited to: application information, license verification, status change, address changes, Kansas Health Care Stabilization Fund information, continuing education information, audit information, and past or current legal issues and documents. This authorization expires one year from the date of signature. You can revoke this authorization at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to receipt of your written request. A reproduction of this authorization shall have the same effect as the original. Email to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail it directly to the Board.

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I, \_\_\_\_\_, authorize Board staff to release and discuss any and all information pertaining to my application, with the following individuals:

1. Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Relationship: \_\_\_\_\_

2. Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Relationship: \_\_\_\_\_

I acknowledge by my signature, that although I am not required to authorize the Board to release information to third parties, I am giving my consent for Board staff to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information which has already been released with consent, prior to my revocation.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



## GENERAL INFORMATION AND INSTRUCTIONS

Occupational Therapist and Occupational Therapist Assistant

Please visit [http://www.ksbha.org/documents/publications/PracticeHandbook\\_OTOTA.pdf](http://www.ksbha.org/documents/publications/PracticeHandbook_OTOTA.pdf)

for all information governing an Occupational Therapist and Occupational Therapist Assistant License.

Thank you for your interest in becoming licensed in Kansas. Please read the following information very carefully. This information is vital to the successful completion of your application. Often your questions are covered in this form. Please allow two (2) weeks after the submission of the application before contacting our office. **Do not** make a commitment to any work dates prior to being licensed.

It is highly recommended you make and keep copies, for your records, of all items submitted for review. In addition, when mailing you may want to request a delivery confirmation to confirm your application has been received at the Kansas Board of Healing Arts (KSBHA).

One of the missions of KSBHA is public protection through effective licensure and enforcement. One way the public is safeguarded is by issuing licenses to fully qualified, competent and ethical applicants. You will be asked a series of attestation questions. A "yes" answer is not an automatic disqualification from licensure. All applicants are considered on an individual basis. You may be requested to submit information or documents in addition to the requirements mentioned herein before the application will be deemed complete to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. Failure to fully disclose could constitute grounds alone for denial of your application. Please avoid some of the common excuses: "My attorney told me I don't have to disclose." or "I did not think the prior act had anything to do with my profession or that it was still on my record or that it happened so long ago." There is no excuse for not disclosing.

Kansas Application Fees must be submitted with the application and are **NOT** refundable. Kansas application fee is \$80.00. Make checks payable to KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card. To pay by debt or credit card please complete the credit card authorization form.

You must submit any change of address to the Board. Please visit our website to complete the "Change of Address" form.

Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to the Kansas Board of Healing Arts.

The National Practitioner Data Bank (NPDB) Report was mandated by Congress and tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. All applicants include a \$3.00 report fee for the Board to obtain the NPDB report.

Licenses/Certificates expire March 31 and are renewed annually. License renewal will be required of all receiving a permanent license prior to January 1.

### CHECK LIST

#### Did you complete the following?

- ALL** questions answered on the application
- Request verification from states, countries or jurisdictions, if applicable
- Documentation to any "YES" Attestation Questions
- Head and shoulder photograph (size: **2X3** taken within 90 days of application)
- Notarize and sign Oath
- Notarize and sign Release Form
- Fees

Kansas State Board of Healing Arts  
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612  
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov)  
[www.ksbha.org](http://www.ksbha.org)

Revised 9/4/19



## CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Email the completed form to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail directly to the Board. Payments are processed in order of date received.

Name of Applicant/Licensee:	License Number:
Purpose of Payment:	Amount:

*(Application, NPDB Fee, KBI Fee, Verification of Licensure, etc.)*

Name of Cardholder:			
Billing Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	

Card Type:				
Card Number:				
Expiration Date: (MM/YY)		Verification Code:		

*\*Do not add spaces or dashes to numbers*

By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge the above-mentioned amount. I understand that failure to submit the required information will delay processing of the payment.

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please note: The information on this form is considered personal and not subject to disclosure under the Kansas Open Records Act.