



REINSTATEMENT APPLICATION FOR PHYSICIAN ASSISTANT

Completion of this application form is necessary for consideration for licensure. Disclosure of this information is voluntary; however, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application.

Please type or print. When space provided is insufficient, attach additional pages. You may reproduce these blank forms as needed. Please make sufficient copies of all forms before you begin.

1. Kansas License no: \_\_\_\_\_

2. Indicate your full legal name. If your name is different from that shown on your documentation you must submit a copy of the legal document of the name change. If your name is different on your Kansas license you will need to complete the Name Change form.

Full Name: \_\_\_\_\_ first middle last suffix

Other names used, including maiden name: \_\_\_\_\_

3. Include residence, mailing and e-mail address. Residence address may not be a Post Office Box, except qualified participants under the Safe At Home Act, K.S.A. 75-451 et seq. may use substitute residential and mailing addresses.

Residence Address: \_\_\_\_\_ street city county state zip

Mailing Address: \_\_\_\_\_ public information street city county state zip

E-mail: \_\_\_\_\_

4. Daytime phone number (include area code): \_\_\_\_\_

5. Identification. Disclosure of your social security number is required by federal mandates set forth in 42 U.S.C.S. § 666(a)(13). K.S.A. 74-148(a) provides that every application by an individual for a professional license shall require the applicant's social security number.

Social Security/Tax ID. No: \_\_\_\_\_

NPI (National Provider Identifier): \_\_\_\_\_ NPI Not Applicable: [ ]

Are you a U.S. Citizen? Y [ ] N [ ] If you answered NO, are you (check one):

A qualified alien (as defined in 8 U.S.C.A. § 1641). [ ]

A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 et seq). [ ]

An alien who is paroled into the United States under 8 U.S.C.A. § 1182(d)(5) for less than one year. [ ]

A foreign national, not physically present in the United States. [ ]

Other: \_\_\_\_\_

**6. List all professional activities since the time of cancellation of your Kansas license.** Account for all time and explain all gaps in professional activity. Attach an additional sheet if necessary. Include actual work address, not corporate headquarter's address.

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 a physician assistant. Attach an additional sheet if necessary. KSBHA will verify your credentials except for any state that does not provide free and current verifications on their official state website. For those states, you may complete the attached *Licensure Verification* form and forward to all Boards or similar entities in which you have held a PA 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. Recommendation by a peer that has known the applicant for a minimum of 1 year.**

I \_\_\_\_\_, a licensed and practicing physician assistant in the state of \_\_\_\_\_  
(name, please print) (state name)

affirms that \_\_\_\_\_ has been known to me for \_\_\_\_\_ year(s), and that applicant, to  
(name of applicant)

the best of my knowledge is an ethical practitioner, is of good professional character, and not addicted to the use of alcohol or drugs.

\_\_\_\_\_  
signature

\_\_\_\_\_  
address

\_\_\_\_\_  
date

\_\_\_\_\_  
city, state and zip

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

9. Please answer each of the following questions by putting a check in the appropriate box. All “yes” answers MUST be thoroughly explained on 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. A 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.

- (a) 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 program prior to completing the training?
- (b) Yes  No  Have you ever had any application for any professional license refused or denied by any licensing authority?
- (c) Yes  No  Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?
- (d) 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?
- (e) Yes  No  Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?
- (f) 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?
- (g) Yes  No  Have you ever voluntarily surrendered any professional license?
- (h) 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?
- (i) Yes  No  Have you ever been notified or requested to appear before a licensing or disciplinary agency?
- (j) 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?
- (k) Yes  No  Has any professional association imposed any disciplinary action against you?
- (l) 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?
- (m) 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?
- (n) 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?

- (o) 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?
- (p) Yes  No  Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?
- (q) 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?
- (r) Yes  No  Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?
- (s) Yes  No  Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?
- (t) Yes  No  Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.
- (u) 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.
- (v) Yes  No  Have you ever been court martialled or discharged dishonorably from the armed services?
- (w) 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?
- (x) Yes  No  Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?
- (y) 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?

**Additional information, reference the question letter and include date, place, reason and disposition of the matter. Attach all relevant legal documentation.**

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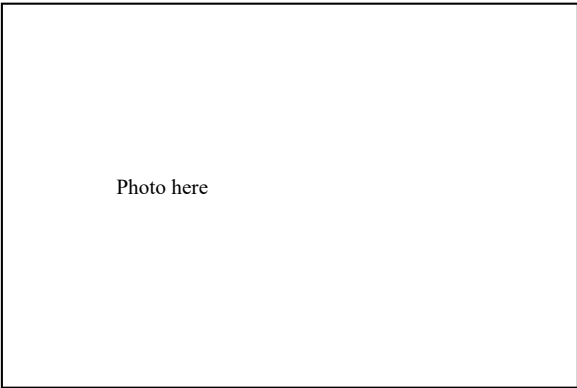
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**10. Photo.**

Attach a **2"x 3" wallet size photograph** of applicant with head and shoulder areas only. The photograph must have been taken within 90 days prior to date of application. Proof photographs, negatives, copies of photographs, poor quality, photographs cut from books, newspaper articles or passport photos are **NOT** accepted.



**11. License Designation.** Please select the license designation you are requesting.

- Active  A license issued to a person engaged in the practice as a physician assistant. 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. A current active practice form and written agreement must be on file with the Board.
- Federal Active  A license issued to a person who meets all the requirements for a license to practice as a physician assistant and who practices as a physician assistant solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies. Each federal active license may be renewed annually. A current active practice form and written agreement must be on file with the Board. Individuals must maintain and submit evidence of satisfactory completion of continuing education hours.
- Inactive  A license issued to a person who meets all the requirements for a license to practice as a physician assistant and who does not engage in active practice as a physician assistant in the state of Kansas. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit a Responsible Physician and Drug Prescription Protocol. Individuals must maintain and submit evidence of satisfactory completion of continuing education hours.
- Exempt  A license issued to a person who is not regularly engaged in the practice as a physician assistant in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. The holder of an exempt license may serve as a paid employee or unpaid volunteer of a local health department as defined by K.S.A. 65-241, or an indigent health care clinic as defined by K.S.A. 75-6102. Each exempt license may be renewed annually. Individuals must maintain and submit evidence of satisfactory completion of continuing education hours. A current active practice form and written agreement must be on file with the Board.

**12. Oath must be signed by applicant and notarized.**

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents. 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 as a physician assistant in the state of Kansas and may subject me to a fine not exceeding \$10,000 and term of imprisonment not exceeding 5 years of each violation (K.S.A. 21-3805).

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

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

SEAL here

\_\_\_\_\_  
Notary Public  
\_\_\_\_\_  
Commission Expires

**13. Continuing Education:** Include proof of completion of continuing education as required by K.A.R. 100-28a-16, if applicable.

**14. Malpractice Insurance:** Include proof of professional liability insurance and participation with the Kansas Health Care Stabilization Fund as required by K.S.A. 65-28a03(e), if applicable.

**15. Application fee of \$250.00 and NPDB report fee of \$3.00. 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)

revised 1/14/16, kl



### Third Party Authorization

Must be signed by applicant and notarized.

I, \_\_\_\_\_, hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Kansas State Board of Healing Arts or its successors any information, files or records requested by the Board in connection with this application. I further authorize the Kansas State Board of Healing Arts or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure.

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

SEAL here

Sworn to before me this \_\_\_\_\_ day of

\_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_ Notary Public

\_\_\_\_\_ Commission Expires



## GENERAL INFORMATION AND INSTRUCTIONS

### Physician Assistant

Please visit <http://www.ksbha.org/statutes/booklets/physicianassistant.pdf>  
for all information governing a Physician 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 State 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 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 \$250.00. 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.

Each person applying for an active license must submit to the Board evidence of professional liability insurance and participation in the Kansas Health Care Stabilization Fund as required by KSA 65-28a03(e).

The National Practitioner Data Bank (NPDB) Report was mandated by Congress and tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. For all applications postdated on or after October 1, 2014 include a \$3.00 report fee for the Board to obtain the NPDB report.

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

### CHECK LIST - Did you complete the following?

|   |   |
|---|---|
| <u>ALL</u> questions answered on the application  | Complete and sign the written agreement form, if required |
| Request verification from states, countries or jurisdictions, if applicable   | Proof of continuing education, if required                |
| Signature of recommendation #8  | Fees  |
| Documentation to any "YES" answers to #9  |   |
| Head and shoulder photograph #10  |   |
| Notarize and sign Oath #12  |   |
| Notarize and sign Release Form  |   |
| Proof of professional liability insurance and participation in the Kansas Health Care Stabilization Fund, if required |   |

revised 1/14/16, kl

800 SW Jackson, Lower Level-Suite A., TOPEKA KS 66612

Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: [www.ksbha.org](http://www.ksbha.org)



## CREDIT CARD PAYMENT AUTHORIZATION

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



### CARD NUMBER

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

### Verification Code

3-4 digit non-embossed number found on the card signature panel

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

### Expiration Date

MO  / YR

Name (as it appears on the credit card):

Billing Address:      
Street City State Zip

Telephone Number:  -  -

Payment Amount \$  Purpose of Payment:   
(e.g. renewal, application)

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 1/28/11, kl





**STATE VERIFICATION FORM**

Send to all states in which a license or registration has ever been issued. 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 return 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; formal, informal, pending, closed or any other pertinent information.

Full Name: \_\_\_\_\_  
Other Names Used (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
License or Registration No.: \_\_\_\_\_ Issue Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Profession: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name of licensee or registrant: \_\_\_\_\_  
License or Registration No.: \_\_\_\_\_ Status: \_\_\_\_\_  
Issue Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
License Method: \_\_\_\_\_ School: \_\_\_\_\_

**DISCIPLINARY ACTIONS:**  
Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?  Yes  No  Unable to Divulge

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

Comments \_\_\_\_\_

Signature \_\_\_\_\_ (SEAL)  
Title \_\_\_\_\_  
State Board of \_\_\_\_\_  
Date \_\_\_\_\_

Complete for Active and Exempt license only



# Physician Assistant Active Practice Request Form and Written Agreement

Please enter required information , including dates and signatures.  
Mail form to KSBHA, 800 SW Jackson LL, Ste. A., Topeka, KS 66612 or fax to 785-296-0852.

Please refer to the detailed instructions at the end of the form.

## Section I - Physician Assistant Information

Physician Assistant's Name \_\_\_\_\_

Kansas License Number: \_\_\_\_\_ or Pending, application on file

License Designation: Active  Federal Active  Exempt

Reason for submitting form: New supervisory relationship  New written agreement for an additional practice

Modification of existing written agreement or replacement of previous *Responsible Physician and Drug Prescription Protocol*

DEA Number: \_\_\_\_\_ N/A

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## Section II - Kansas Supervising Physician Information

Name: \_\_\_\_\_ Kansas License Number: \_\_\_\_\_

Does the supervising physician engage in practice in Kansas? Yes  No

DEA Number: \_\_\_\_\_ N/A  Specialty/Practice Area: \_\_\_\_\_

Describe methods of communication between supervising physician and physician assistant when not at the same location:

\_\_\_\_\_

Describe the procedure to be followed for addressing patient emergencies:

\_\_\_\_\_

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## Section III - Kansas Substitute Supervising Physician(s) Information (use additional pages if more than two).

Name: \_\_\_\_\_ Kansas License Number: \_\_\_\_\_

Does the substitute supervising physician engage in practice in Kansas? Yes  No

DEA Number: \_\_\_\_\_ N/A  Specialty/Practice Area: \_\_\_\_\_

Name: \_\_\_\_\_ Kansas License Number: \_\_\_\_\_

Does the substitute supervising physician engage in practice in Kansas? Yes  No

DEA Number: \_\_\_\_\_ N/A  Specialty/Practice Area: \_\_\_\_\_

**Section IV - Written Agreement**

Complete written agreement for **each** facility/practice location where medical services are provided by the physician assistant (use additional pages if more than one location).

**A. Practice Location Information**

Name of Facility/Location \_\_\_\_\_ Street Address \_\_\_\_\_ City and State \_\_\_\_\_ Zip Code \_\_\_\_\_

Is this Locum Tenens practice? Yes  No  If yes, anticipated Time frame: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Practice Setting: Office Practice  Clinic  Hospital  ASC  Nursing Home

Other  \_\_\_\_\_

Is this a "different practice location" as defined in K.A.R. 100-28a-1(b)? Yes  No

If yes, are the requirements of K.A.R. 100-28a-14 met? Yes  No

Substitute Supervising Physician(s) for this location: \_\_\_\_\_

For this practice location, describe the procedure to be used to notify a substitute supervising physician of the supervising physician's absence or other unavailability: \_\_\_\_\_

**B. Scope of Practice for this Location**

Description of the scope of medical services and procedures that the Physician Assistant is authorized to perform at this practice location (use additional pages if necessary). \_\_\_\_\_

Do any of the medical services and/or procedures require a specific type of supervision by the supervising physician or substitute supervising physician as defined in K.A.R.100-28a-1a(c), (e) or (f)? Yes  No

If yes, please specify below:

| <u>Type of Supervision</u> | <u>Medical Services/Procedures</u> |
|----------------------------|------------------------------------|
| Direct                     | _____                              |
| Indirect                   | _____                              |
| Off-site                   | _____                              |

If applicable, list any other restriction or exclusion on the Physician Assistant's authorized scope of practice: \_\_\_\_\_

DNR Order Authority? Yes  No

**C. Prescription - Only Drug Authority for this location**

The Physician Assistant is authorized to prescribe and administer **non-controlled** prescription drugs as follows:

All  None  All with Exceptions

Specify Exceptions \_\_\_\_\_

Physician Assistant's Name: \_\_\_\_\_

Supervising Physician's Name: \_\_\_\_\_

Within the limitations set forth in K.S.A. 65-28a08(b)(2), the Physician Assistant is authorized to dispense non-controlled prescription drugs as follows: All  None  All with Exceptions

Specify Exceptions \_\_\_\_\_

The Physician Assistant is authorized to distribute non-controlled, professional drug samples? Yes  No

The Physician Assistant is authorized to prescribe and administer controlled substances as follows:

|                        | NONE                     | All                      | All EXCEPT, specify:           |
|------------------------|--------------------------|--------------------------|--------------------------------|
| Schedule II and II-N   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Schedule III and III-N | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Schedule IV            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Schedule V             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |

Within the limitations set forth in K.S.A. 65-28a08(b)(2) and other applicable state and federal laws, the Physician Assistant is authorized to dispense controlled substances as follows:

|                        | NONE                     | All                      | All EXCEPT, specify:           |
|------------------------|--------------------------|--------------------------|--------------------------------|
| Schedule II and II-N   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Schedule III and III-N | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Schedule IV            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Schedule V             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |

Physician Assistant's DEA number to be used when practicing at this location (if different from page one): \_\_\_\_\_

Do the Supervising Physician and Physician Assistant have DEA registrations for all the schedules authorized above?  
Yes  No

**D. Attestations and Signatures for this Practice Location** (use additional pages for signatures if more than 2 substitute supervising physicians)

\*I confirm the medical services and procedures authorized are within the clinical competence and customary practice of the supervising physician and all substitute supervising physicians as required by K.A.R. 10-28a-10.

\*I understand that the supervising physician or a substitute supervising physician shall be available for communication with the physician assistant at all times during which the physician assistant could reasonably be expected to provide professional services.

\*I confirm that the supervising physician has established and implemented a method for the initial, periodic and annual evaluation of the physician assistant's professional competency required by K.A.R. 100-28a-10.

\*I understand that failure to adequately supervise the physician assistant in accordance with the Physician Assistant Licensure Act or rules and regulations adopted under such statutes by the Board, shall constitute grounds for revocation, suspension, limitation or censure of a supervising physician's license to practice medicine and surgery in the State of Kansas.

\*I confirm that a current copy of this form shall be provided to the Board office and maintained at the usual practice locations of the supervising physician and that any changes or amendments thereto will be provided to the Board within 10 days of being made.

\*I have carefully read the questions in the foregoing request form and have answered them completely, and I declare under penalty of perjury that my answers and all statement contained herein are true and correct.

\_\_\_\_\_  
Signature of supervising physician      Date

\_\_\_\_\_  
Signature of physician assistant      Date

\_\_\_\_\_  
Signature of substitute supervising physician      Date

\_\_\_\_\_  
Signature of substitute supervising physician      Date

Physician Assistant's Name: \_\_\_\_\_

Supervising Physician's Name: \_\_\_\_\_

## **Physician Assistant Active Practice Request Form and Written Agreement Instructions**

### **General Information:**

Many amendments to the Physician Assistant Licensure Act and temporary regulations became effective January 11, 2016, and greatly affect PA practice in Kansas. Those changes expanded scope of practice for PAs and increased the number of PAs that one physician can supervise. Consequently, increased information must be provided to the Kansas Board of Healing Arts about each supervisory relationship and practice location. Physicians and PAs should familiarize themselves with the statutes and regulations regarding PA practice and supervision. The information provided in these instructions should not be construed as legal advice or complete information about the requirements for PA practice and supervision. The statutes and regulations may be found on the agency website at [www.ksbha.org/statsandregs.shtml](http://www.ksbha.org/statsandregs.shtml)

**New Forms:** PAs must now complete an “Active Practice Request Form” (APR form) as a condition of engaging in practice in Kansas. Effective January 11, 2016, the APR form replaces the “Responsible Physician and Drug Prescription Protocol” form. There is a “Written Agreement” section of the APR form which specifies the details of the PA's delegated practice authority at each practice location where the PA works.

**PAs Practicing Under Old Forms:** Currently practicing PAs who enter into a *new* supervisory relationship must complete an APR form prior to practicing. PAs currently practicing under an existing supervisory relationship who have previously submitted a “Responsible Physician and Drug Prescription Protocol” will have until July 1, 2016, to submit the new APR form and Written Agreement(s) for their existing practice locations.

### **General Instructions:**

An APR form is required for *each* Physician-PA supervisory relationship. Additionally, the “Written Agreement” portion of the APR form is required for *each* location where the PA will practice under that supervisory relationship. The Written Agreement for each practice location requires information about the practice location, the scope of practice and prescription drug authority of the PA, and the substitute supervising physician for that specific location. PAs practicing at multiple locations will need to submit a Written Agreement for each separate location including office-practices, clinics, hospitals, nursing homes, surgery centers, hospice facilities, etc. Signatures of the PA, supervising physician and substitute supervising physician(s) must be on each Written Agreement.

**New Practice Locations Added or Other Changes:** Every time a new practice location is added, a new Written Agreement must be submitted to the Board within 10 days. Additionally, any other changes to the APR form must be submitted to the agency within 10 days of being made (examples- changes in scope of practice, prescribing authority, substitute supervising physician, types of supervision, etc.)

**Names at bottom of each page:** Please include the name of the PA and the Supervising Physician on each page of the form and on any supplemental pages in case the pages become separated. Pages submitted without this information will not be accepted.

**Filling Out the Forms:** The APR form and included pages for the Written Agreement are in a fillable PDF format. Information can be entered on the form and then printed and signed. Hand-written signatures are required. If additional space is needed to complete the information required in a section of the form, please attach supplemental pages. Incomplete forms will not be accepted.

You may wish to save your electronically filled-out PDF form on your computer so the information is readily available if amendments, additional practice locations, or changes in substitute supervisors need to be made in the future and submitted to the agency. If you hand-write the form, retain a working copy to be edited in the future if needed.

### **Section I- PA Information:**

- Please provide all requested information for the Physician Assistant.
- Name- as it appears on license or application for licensure.
- Provide license number or indicate if a pending application has been submitted to the agency.
- Indicate if the PA's license designation is active or exempt (practice limited by K.S.A. 65-28a03(g))
- List the PA's DEA number if the PA will have controlled-substance drug authority.

### **Section II- Supervising Physician Information:**

- Please provide all requested information for the Supervising Physician (M.D. or D.O.) who will delegate medical services and procedures to be performed by the PA and supervise the PA's practice.
- Name- as it appears on the Supervising Physician's license.
- Indicate whether the Supervising Physician practices in Kansas. Supervising Physicians are required to engage in the practice of medicine and surgery in Kansas pursuant to K.A.R. 100-28a-10(a)(1).
- List the Supervising Physician's DEA number if the PA will have controlled-substance drug authority.
- Provide the Supervising Physician's specialties or practice areas (cardiology, family practice, hospitalist, bariatrics, etc.) A Supervising Physician may only delegate acts which are within their clinical competence and customary practice.
- Indicate how the Supervising Physician and PA will communicate regarding patient care when both are not at the same location (phone, text, e-mail, etc.)
- Specify the agreed-upon plan the PA will follow if a patient has an emergency medical condition which requires treatment that exceeds the PA's authorized scope of practice or clinical competence.

### **Section III- Substitute Supervising Physician(s) Information:**

- Please provide all requested information for **all** Substitute Supervising Physicians who have been designated by prior arrangement to provide supervision of the PA in the Supervising Physician's absence. This may be a single physician or multiple. Each Substitute Supervising Physician designated has the same requirements as the Supervising Physician when he/she is supervising the PA.
- Space on the form is provided to list two Substitute Supervising Physicians. Use additional pages to provide the requested information if there is more than two Substitute Supervising Physicians.
- Name- as it appears on the Substitute Supervising Physician's license.
- Indicate whether the Supervising Physician practices in Kansas. Substitute Supervising Physicians are required to engage in the practice of medicine and surgery in Kansas pursuant to K.A.R. 100-28a-10(a)(1).
- List the Substitute Supervising Physician's DEA number, if the PA will have controlled-substance drug authority.
- Provide the Substitute Supervising Physician's specialties or practice areas (cardiology, family practice, hospitalist, bariatrics, etc.).

### **Section IV- Written Agreement(s):**

- A separate Written Agreement is required for **each** location where the PA will practice. Use additional pages if there is more than one practice location.

#### **Subsection A- Practice Location Information:**

- Complete address and telephone information about the specific practice location is required.
- Indicate if the PA's practice at the location is a locum tenens placement and the anticipated timeframe if known.
- Indicate they type of practice setting for the location.
- Indicate if the practice location is a "different practice location," which is a practice location where the supervising physician is **physically present** less than 20% of the time services are provided at the location. It is important to note that "medical care facilities" defined in K.S.A. 65-425(h), such as hospitals, ambulatory surgery centers and rehabilitation centers, are **not** considered "different practice locations" even if the supervising physician is physically present less than 20% of the time services are provided to patients.
- If the location meets the definition of "a different practice location," indicate whether the specific requirements of K.A.R. 100-28a-14 are met (PA has had 80 hours of direct supervision; a physician provides in-person care at the location at least once every 30 days; written notice that location is primarily staffed by a PA is posted where likely to be seen by patients).
- Specify who the Substitute Supervising Physicians are for the location.

- Describe the agreed-upon procedure for the Substitute Supervising Physician to be notified if the Supervising Physician is absent or unavailable (examples- standing agreement to cover on Wednesday mornings supervisor is in surgery; substitute is notified of PA's work hours each week and ensures availability by phone or text during those times; substitute is on clinic premises during all times PA works, etc.).

**Subsection B- Scope of Practice for this Location:**

- Describe the scope of practice delegated to the PA at the specific practice location.
- Indicate any delegated medical services or procedures which shall require specific types of supervision by the Supervising Physician or Substitute Supervising Physician. It is **optional** to require specific types of supervision for certain medical services or procedures performed by the PA. The different types of supervision are defined in K.A.R. 100-28a-1a as **direct** (physical presence of supervising physician or substitute), **indirect** (physical presence of supervising physician or substitute at site of patient care within 15 minutes), or **off-site** (supervising physician or substitute is immediately available by telephone or other electronic communication).
- If there are any other restrictions/exclusions to the PA's delegated scope of practice, they should be listed in the space provided on the form (examples- no self-prescribing, colposcopies, newborn care, etc.)
- Specify if the PA has authority to write DNR orders.

**Subsection C- Prescription-Only Drug Authority for this Location:**

- Indicate the PA's authority to prescribe, administer and dispense **non-controlled** prescription drugs in the corresponding sections on the form. If there are exceptions to the PA's authority, those should be explicitly specified.
- Please note that a PA's authority to dispense prescription drugs is limited by K.S.A. 65-28a08(b)(2). A PA may only dispense prescription drugs if pharmacy services are not readily available; dispensing is in the best interests of the patient; and the quantity of drugs dispensed do not exceed a 72-hour supply. Authority to dispense must be indicated on the Written Agreement.
- Indicate if the PA is authorized to distribute **non-controlled** professional drug samples at the practice location.
- Indicate the PA's authority to prescribe, administer and dispense **controlled substance** prescription drugs in the corresponding sections on the form. If there are exceptions to the PA's authority, those should be explicitly specified.
- List the PA's DEA number to be used when practicing at this location if different from the DEA number listed on the first page of the APR form.
- Indicate if the Supervising Physician and PA both have DEA registrations for all of the schedules of controlled substances the PA is authorized to prescribe, administer or dispense. A Supervising Physician cannot delegate authority that he or she does not have themselves.

**Subsection D- Attestations and Signatures for this Practice Location:**

- The PA, Supervising Physician and all Substitute Supervising Physicians for this location should carefully read each of the statements before signing.
- Dated signatures of the Supervising Physician, PA and Substitute Supervising Physician(s) are required. If there are more than 2 Substitute Supervising Physicians for this practice location, use additional pages.



**AUTHORIZATION AND RELEASE INFORMATION**

Please complete if you would like for Board staff to talk with others concerning your application.

I, \_\_\_\_\_, hereby authorize the Kansas State Board of Healing Arts ("Board")  
print name

to release and discuss any and all information pertaining to my application pending before the Board with the following **TWO** individual(s):

Name of Individual                      Phone Number                      E-mail Address                      Relationship to Individual

\_\_\_\_\_

- Application Information (Initial, Reinstatements, Renewals, etc.)     Payment Information     License Verifications
- Status Changes     Address Changes     Healthcare Stabilization Fund Information     Continuing Education Information
- Audit Information     Former and/or Current Legal Documents     Former and/or Current Legal Issues

Name of Individual                      Phone Number                      E-mail Address                      Relationship to Individual

\_\_\_\_\_

- Application Information (Initial, Reinstatements, Renewals, etc.)     Payment Information     License Verifications
- Status Changes     Address Changes     Healthcare Stabilization Fund Information     Continuing Education Information
- Audit Information     Former and/or Current Legal Documents     Former and/or Current Legal Issues

This Authorization and Release **expires one year** from date of signature reflected on this form. Prior to expiration, this Authorization and Release may be revoked in writing at any time. A reproduction of this Authorization and Release shall have the same effect as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date