Print Form

RENEWAL OF PHYSICIAN ASSISTANT LICENSE
JANUARY 1, 2017 TO JANUARY 31, 2018

ONLINE RENEWAL IS AVAILABLE at www.ksbha.org from Nov. 15, 2016 to Jan. 31, 2017. **Do not** submit a paper renewal application if you have completed the online renewal process.

The renewal application and fee must be received postmarked by **December 31, 2016** to renew your license. A late fee must be paid for renewal applications completed on-line or received postmarked **January 1, 2017 or later.** If an online renewal or complete renewal application is not received postmarked on or before **January 31, 2017** the license will be cancelled. Any person desiring to reinstate a cancelled license must contact the Board office for the appropriate form. **A license will not be renewed if the application is not complete.** Please print or type all responses.

1. License Number: _____ **2. Name:** _____

3. NPI (National Provider Identifier): _____ ☐ n/a

4. DEA registration number(s): _____ ☐ n/a

5.. Addresses: ☐ I have had a change of address since the last renewal

Mailing Address: _____
Street or PO BOX City County State Zip

Residence Address: _____
Street City County State Zip

Telephone / Cell : _____ / _____

Business Address (May **not** be a Post Office Box. Additional business addresses may be submitted on a separate page.)

_____
Street City County State Zip

Telephone / Fax: _____ / _____

E-mail: _____

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6. License Type Change (Complete ONLY if you wish to change your license type): To verify your current license type review your wallet card, visit our website at www.ksbha.org and click verification and follow the instructions, or call 785-296-2575.

I would like to change my current license type of: _____ effective _____ to:

☐ **Active** - Active Practice Request form required - see parts 9,13,15,16 & 17. Download, complete and return the Active Practice Request form. The form and instructions are available on our website.

☐ **Inactive** - Does not allow the holder to provide professional services in Kansas.

☐ **Federal Active** - Practice 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. see part 13. Download, complete and return the Active Practice Request form.

☐ **Exempt** - Allows a person to serve as a paid employee of a local health department or indigent health care clinic - see parts 9, 13, 15 &16. Download, complete & return the Active Practice Request form.

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7. Identify all other authorities that have licensed you to practice as a Physician Assistant (All License Types)
use additional pages if necessary: ☐ I have not been or currently licensed in another state.

State _____ State _____ State _____ State _____ State _____

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Office Use Only

8. **You must answer the following questions. (All License Types)** Attach documentation and an explanation if your answer is "yes"

(a) ☐ Yes ☐ No In the past 12 months have you been and/or have you continued to be a defendant or has any judgment, award or settlement been paid on your behalf as a result of a professional liability claim?

(b) ☐ Yes ☐ No In the past 12 months have you been arrested, charged with or convicted of any felony, misdemeanor or the military equivalent? This includes a diversion of plea to a felony, misdemeanor or the military equivalent.

(c) ☐ Yes ☐ No In the past 12 months has any disciplinary action been initiated or taken against you by any state or government agency, or have you been denied a license, had any adverse action taken on your license, surrendered or consented to limitation of your license to practice in any state or country?

(d) ☐ Yes ☐ No In the past 12 months have any privileges related to your profession as a health care provider been suspended, restricted, limited or voluntarily surrendered or has any peer review or professional association initiated or taken any action against you?

(e) ☐ Yes ☐ No In the past 12 months have you suffered from any impairment which might affect your ability to safely practice, been referred to and/or participated in a progoram for impaired providers?

(f) ☐ Yes ☐ No In the past 12 months have you been the subject of any investigation, including in Kansas, regarding allegations, complaints or by any state licensing agency or other government agency?

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9. **Responsible Physician (Active, Federal Active & Exempt License Types Only)**

Name _____ License No. _____

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10. **Kansas Hospital Privileges (Active, Federal Active & Exempt License Types Only)** use additional pages if necessary:
☐ n/a

Facility Name	City	State	Facility Name	City	State
Facility Name	City	State	Facility Name	City	State

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11. **Professional Services during an Emergency (All License Types)**

Are you willing to be included on a registry of potential volunteers to provide your professional services during an emergency? Please check all that apply. ☐ Please do not include me in the registry ☐ Within the county of residence

☐ Within 75 miles of your residence ☐ Anywhere in the state of Kansas ☐ Outside of the state of Kansas

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12. **Medical Malpractice Screening Panel (All License Types)**

Pursuant to K.S.A. 65-4901, the Kansas State Board of Healing Arts is required to maintain and make available a current list of health care providers who are willing and available to serve on a medical malpractice screening panel.

Are you willing to serve on a malpractice screening panel? ☐ Yes ☐ No

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13. **Continuing Education (All License Types with 2016 CME Year Only):** To verify your current license type review your wallet card, visit our website at www.ksbha.org and click verification and follow the instructions or call 785-296-2575.
CME Year: _____

The Board will verify compliance with continuing education requirements in an undetermined percentage of renewal applications. This verification will involve an audit of records maintained by the licensee. You must maintain your continuing education records for a three year period in a manner that allows them to be readily produced. I understand the audit process and I have met the hours for the following continuing education update.

☐ **50 total hours** with a minimum of 20 Category I hours and a maximum of 30 Category II hours from 01-01-2016/ 12-31-2016, or I am currently certified and in good standing with National Commission on Certification of Physician Assistants (NCCPA).

☐ **100 total hours** with a minimum of 40 Category I hours and a maximum of 60 Category II hours from 01-01-2015/ 12-31-2016, or I am currently certified and in good standing with National Commission on Certification of Physician Assistants (NCCPA).

DO NOT mail in proof of your continuing education with the renewal form unless you are changing your license type to active or federal active

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14. Public Profile (All License Types): Pursuant to KSA 65-28, 131, on and after July 1, 2010, the board shall make available on a searchable website which shall be accessible by the public, the following information regarding licensees:

(1) The licensee's full name, business address, telephone number, license number, type, status and expiration date;

(2) the licensee's practice specialty, if any, and board certifications, if any;

(3) any public disciplinary action taken against the licensee by the board or by the licensing agency of any state or other country in which the licensee is currently licensed or has been licensed in the past;

(4) any involuntary limitation, denial, revocation or suspension of the licensee's staff membership or clinical privileges at any hospital or other health care facility, and the name of the hospital or facility, the date the action was taken, a description of the action, including any terms and conditions of the action and whether the licensee has fulfilled the conditions of the action;

(5) any involuntary surrender of the licensee's drug enforcement administration registration; and

(6) any final criminal conviction or plea arrangement resulting from the commission or alleged commission of a felony in any state or country.

At the time of licensure or renewal, a licensee may add a statement to such licensee's profile as it appears on the website created herein. Such statement may provide further explanation of any disciplinary information contained in your profile. **Do you wish to add a statement to further explain any disciplinary information contained in your public profile? This statement must be received by the Board within 30 days after your license expiration date.** ☐ Yes ☐ No

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15. Protocols (Active, Federal Active & Exempt License Types Only): KAR 100-28a-9(i) requires that a current copy of your physician request form be maintained at each practice location AND that any changes in your practice, drug and prescription protocol, practice location, or supervision be provided to the Board of Healing Arts within 10 days. HAVE YOU SUBMITTED A CURRENT COPY OF THIS FORM? ☐ Yes ☐ No If you answer no, please submit a current Active Practice Request form. The form is available to download from our website at www.ksbha.org.

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16. Dispensing (Active, Federal Active & Exempt License Types Only): KSA 65-28a08 allows a physician assistant on or after January 11, 2016, upon authorization by a supervising physician, to dispense prescription-only drugs, in accordance with the rules and regulations. The dispensing of prescription-only drugs must be in the best interest of the patient when pharmacy services are not readily available and cannot exceed the quantity necessary for a 72-hours supply. On or after January 11, 2016, will you be authorized by your supervising physician to dispense prescription only drugs pursuant to KSA 65-28a08? ☐ Yes ☐ No

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17. Liability Insurance (Active License Type Only) As a condition of providing professional services in Kansas, each person with an active license, must pay the annual surcharge to the Kansas Health care Stabilization Fund (KHCSF) and maintain a policy of professional liability insurance as required by K.S.A. 40-3402, and K.S.A. 40-3404. The Board will verify compliance with liability insurance requirements in an undetermined percentage of renewal applications. This verification will involve an audit of records maintained by the licensee. You must maintain your liability insurance records for a three (3) year period in a manner that allows them to be readily produced. I understand the audit process and

☐ I maintain a policy of liability insurance that complies with Kansas statutes & have paid the annual surcharge to KHCSF.

Insurer	Policy Number	Effective Date	Expiration Date

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18. Renewal Fee: $150.00 ($215.00 if postmarked January 1 or later).

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19. Pursuant to KSA 65-28,131, information provided herein may be deemed public and posted on our website. Failure to furnish the Board any information legally requested by the Board may be deemed unprofessional conduct and may be the basis for disciplinary action. Pursuant to KSA 65-12-126, licensees are required to notify the Board in writing within 30 days of any changes in the licensee's mailing and/or practice address. By this submission I hereby certify that I am the licensee named in this renewal application and I have personally submitted all data requested in the renewal application form. I understand that Kansas Statutes allow the Board to revoke, suspend or limit a license, censure the license, or impose a fine in an amount up to $5,000 for any act of fraud or misrepresentation in applying for renewal of a license.

I declare, under penalty of perjury under the laws of the state of Kansas that the foregoing is true and correct.

Signature: _____ **Date:** _____

PLEASE RETURN TO:

Kansas State Board of Healing Arts, Attn: Licensing, 800 SW Jackson, Lower Level, Ste A, Topeka, KS 66612

website: www.ksbha.org voice : 785 296-2575

CREDIT CARD PAYMENT AUTHORIZATION

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

☐ DISCOVER NETWORK ☐ MasterCard ☐ AMERICAN EXPRESS ☐ VISA

CARD NUMBER

Verification Code

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

Expiration Date

MO / YR

Name (as it appears on the credit card): _____

Billing Address: _____ _____ _____ _____
Street City State Zip

Telephone Number: _____ - _____ - _____

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

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

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

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