



## GENERAL INFORMATION POSTGRADUATE PERMIT

Thank you for your interest in becoming licensed in Kansas. Please read the following information carefully. This information is vital to the successful completion of your application and often, questions you may have are covered. For all information governing the practice of Medicine and Surgery in Kansas, please visit the [Statute and Regulation Handbook](#).

The application and all forms are fillable PDFs and can be submitted electronically by emailing [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov). If a seal or notary is required, it must be clearly visible to be accepted by email. **Pages 1-3 of the application will not be accepted handwritten.** KSBHA highly recommends that you make and keep copies of all the items you submit to the Board. As a reminder, **please do not commit to work dates prior to being licensed. Postgraduate permits are not effective prior to the start date of the program.**

Applications are processed in order of date received. Please allow **at least 2 to 4 weeks** for the processing of your application. After an application is processed a missing requirement letter (“MRL”) is sent to the preferred email address. Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application. For updates, login to the online portal using the registration code listed in the MRL. When a license or permit is issued a notification with the wallet card is sent to the preferred email address.

**Your permit will cancel on the completion date provided by the postgraduate program or upon receipt of full licensure, whichever occurs first. In the event you cease to be engaged in the postgraduate program you must notify the Board within 7 business days.**

**Fees:**

Application: **\$50**

Background Check: **\$47**

NPDB: **\$3**

**ALL FEES ARE NON-REFUNDABLE**

If you:	Then complete the:
Never held a Kansas Postgraduate permit	Initial Application
Have held a Kansas Postgraduate permit and it has or will expire	Supplemental Application

**Postgraduate Permit Application Requirements Check List:**

Complete application with all questions answered.
Request official transcript with final medical degree awarded be sent directly to the board.
Request medical school complete the Letter of Completion if transcript with final degree is not available.
Request postgraduate program complete the Certification of Postgraduate Training Program.
Request verification of other licenses, permits or certifications, if applicable.
IMGs request an ECFMG Certification Status Report be sent directly to the board.
Documentation of professional liability insurance, if applicable.
Documentation for any “YES” answers on the attestation questions.
Documentation of name change, if applicable.
Notarize and sign the Affidavit and Authorization.
Complete Background Check Waiver and fingerprints.
Complete and sign Third Party Release, if applicable.



## APPLICATION INSTRUCTIONS – POSTGRADUATE PERMIT

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**Application Fees:** Application fees must be submitted with the application. These *fees are non-refundable* and will be processed upon receipt. The Kansas Postgraduate permit application fee is **\$50**. Also, a background check fee of \$47 and a National Practitioner Data Bank (“NPDB”) report fee of **\$3** must accompany the application. This totals **\$100**. Board staff directly runs an NPDB report for all applicants. **Please do not submit an NPDB self-query.** To pay by debit or credit card, complete the Credit Card/Debit Card Authorization Form. Please make all checks payable to the KSBHA. Checks returned for any reason by the payer’s financial institution must be replaced by a money order, certified check, or credit card.

**Name:** Provide your full legal name. If the name on the application differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name.

**Identification:** Federal Law, at 42 U.S.C.S. § 666(a)(13), mandates that this agency record social security number on your application. K.S.A. 74-148(a) provides that every application by an individual for a professional license shall request the applicant’s social security number. K.S.A. 74-139 requires this agency to disclose your social security number upon request to the Kansas director of taxation. Your social security number may be provided for child support enforcement actions, to the Kansas director of taxation, or for reporting disciplinary actions to the National Practitioner Data Bank-Health Integrity and Protection Data Bank (NPDB-HIPDB) as required by 45 C.F.R. §§ 61.1 *et seq.* Disclosure by this agency of your social security number is voluntary to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your social security number will not be released for any other purpose not permitted by law.

**Addresses:** Addresses **cannot** be a Post Office Box, except qualified participants under the Safe at Home Act, K.S.A. 75-451 *et seq.* Your home address will not be available to the public. The business address is public and will be posted on the Board’s website. You may consider listing the postgraduate program as the business address. The Board will contact you at the preferred mailing and email address. If your address or contact information changes, you must notify the Board within 30 days by completing the [Change of Address Form](#) or in the [Online Portal](#).

**National Provider Identifier (NPI):** The [NPI](#) is a unique 10-digit numeric identifier for health care professionals available from the Centers for Medicare and Medicaid Services. Provide your NPI number or if you do not have an NPI number check the corresponding box.

**ECFMG Certification:** An ECFMG Certification Status Report is required for all international medical graduates (“IMG”). Request a Certification Status Report be sent directly to the board by visiting <https://cvsonline2.ecfm.org/>. Canadian graduates are not required to submit an ECFMG Status Report.

**Medical School:** In chronological order, list all medical schools you have attended, even those from which you did not graduate. Attach additional page if necessary. Request an **official transcript with the final medical degree awarded** be mailed or sent electronically from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors. Send electronic transcripts to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov). For IMGs, the ECFMG Certification Status Report will be accepted in lieu of an official transcript.

**Postgraduate Training:** In chronological order, list all postgraduate programs you have attended, even those from which you did not complete. Attach additional page if necessary. If you have not participated in a postgraduate program check the corresponding box.



**Employment/Professional History:** In chronological order, list all healthcare employment/professional history for the past five years. Attach additional page if necessary. Include the actual work address, not corporate headquarters. If you have not worked in a healthcare position for the past five years check the corresponding box.

**Other Licenses/Permits/Certifications:** List all state or jurisdictions in which you currently, or have ever held, a healthcare related license, permit, or certification, permanent or temporary. If you have never held a healthcare related license, permit, or certification in another state or jurisdiction check the corresponding box. The Board will verify your credentials for any state or jurisdiction that provides free and current verifications on their official state website and includes the following information: issue date, expiration date, and any pending or past disciplinary action. If the Board is unable to verify your credentials, you may complete the Verification Form and forward to all licensing agencies. Please check with the licensing agency to see if a fee is required for this information prior to sending the form. The Board accepts electronic verifications directly from the licensing agency or their official third-party vendor. Send electronic verifications to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov).

**Professional Liability Insurance and Kansas Health Care Stabilization Fund Compliance:** K.S.A. 40-3402 requires MD, DO, DC, DPM and PAs practicing in Kansas to maintain professional liability insurance of not less than \$200,000 per claim, and not less than \$600,000 annual aggregate for all claims made during the policy period. These professions are also required to maintain compliance with the Kansas Health Care Stabilization Fund (“KHCSF”). K.S.A. 40-3404; K.S.A. 65-2809(c). Submit one of the following as proof of coverage: Certificate of Compliance from the KHCSF, Certificate of Insurance, or a letter of intent from the liability insurance company or employer. The letter of intent must include the insurance company's information, coverage amounts, and coverage dates. Proof of coverage is **not** required if attending the University of Kansas School of Medicine – Kansas City or the University of Kansas School of Medicine – Wichita.

**Attestation Questions:** The mission of the Board is to protect the public which it does so in part, through effective licensure and enforcement. The public is safeguarded by issuing licenses to qualified, competent, and ethical applicants. In the application, you will be asked a series of attestation questions. A “yes” answer to an attestation question is not an automatic disqualification for licensure – each applicant is considered on an individual basis. You may be requested to submit additional information or documents. It is your continued duty to update the Board on any changes once the application has been submitted. Please keep in mind, **failure to fully disclose may constitute grounds for denial of your application.**

**Affidavit and Authorization for Release of Information:** In the presence of a notary public, sign and date this form with a 2 x 3-inch colored photograph, of the head and shoulder areas only, taken within the last 90 days. Black and white photographs, proof photographs, negatives, photographs cut from books or newspaper articles, or poor-quality photographs are **NOT** accepted.

**Letter of Completion:** The Letter of Completion will be accepted in lieu of an official transcript when all degree requirements have been met, and the official transcript with the final degree awarded is not yet available. Complete, sign and date the top portion of this form. Request the school or program complete the bottom portion and return directly to the Board. A seal or notary is required and it must be clearly visible to be accepted by email. The Letter of Completion must be received directly from the school or program.

**Certification of Postgraduate Training Program:** Complete, sign and date the top portion of this form. Request the postgraduate program complete the bottom portion and return directly to the Board. A seal or notary is required and must be clearly visible to be accepted by email. The Certification of Postgraduate Training Program must be received directly from the program.



**Waiver Agreement and FBI Privacy Act Statement:** Complete, sign and date the top portion of this form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

**Fingerprints:** Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the **fingerprints must be printed on the fingerprint card** and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or call (785) 296-7413. Be aware that fingerprint processing may delay your application. Please make it a priority to complete the fingerprint process.

**Third Party Release:** Complete this form if you would like Board staff to talk with third parties about your application.

**How to Check the Status of Your Application:** Once your application is received and processed, you will be notified via email of any missing items and how to check the status of your application online.



## POSTGRADUATE PERMIT APPLICATION

Completed application and forms can be emailed to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mailed to the Kansas State Board of Healing Arts. If a seal or notary is required, it must be clearly visible to be accepted by email. **Pages 1-3 of the application will not be accepted handwritten.**

### FULL LEGAL NAME/IDENTIFICATION

Provide your full legal name. If the name on the application differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name.

First Name:	Middle Name:	Last Name:	Suffix:
List all other names used, including maiden name:			
Social Security Number:		Date of Birth: (MM/DD/YYYY)	
Place of Birth:		Male <input type="checkbox"/>	Female <input type="checkbox"/>

### ADDRESSES

Addresses cannot be a Post Office Box, except qualified participants under the Safe at Home Act, K.S.A. 75-451 *et seq.* Your home address will not be available to the public. The business address is public and will be posted on the Board’s website. You may consider listing the postgraduate program as the business address. The Board will contact you at the preferred address.

Home Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	
Business Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	
Preferred Address: (mailed and emailed correspondence will be sent to the selected address) Home <input type="checkbox"/> Business <input type="checkbox"/>			

### LEGAL AUTHORITY TO WORK IN THE U.S.

Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No 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 <i>et seq.</i> ).
	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 Unites States.
	Other:

### NATIONAL PROVIDER IDENTIFIER (NPI)

The NPI is a unique 10-digit numeric identifier for health care professionals available from the Centers for Medicare and Medicaid Services (“CMS”). Provide your NPI number or if you do not have an NPI number check the corresponding box.

NPI Number:	I do not have an NPI number <input type="checkbox"/>
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### ECFMG CERTIFICATION

For IMGs, provide your ECFMG certification number and date issued. Request a Certification Status Report be sent directly to the board. If you are not an IMG check the corresponding box.

Certificate Number:	Issue Date:	I do not have an ECFMG Number <input type="checkbox"/>
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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)



**MEDICAL SCHOOL**

In chronological order, list all medical schools you have attended, **even those from which you did not graduate.** Attach additional page if necessary. Request an official transcript with the final medical degree awarded be sent from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors.

Name of Medical School:			
City:	State:	Start Date:	End Date:
Degree Awarded:			Date Awarded:

**POSTGRADUATE TRAINING**

In chronological order, list all postgraduate programs you have attended, even those from which you did not complete. Attach additional page if necessary. If you have not participated in a postgraduate program check the corresponding box.

I have never attended a postgraduate program <input type="checkbox"/>			
Training Type: <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other:			
Name of Hospital:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:	Start Date:	End Date:	
Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In progress, expected completion date:			
Accredited By: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> RCPSC <input type="checkbox"/> Other:			

Training Type: <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other:			
Name of Hospital:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:	Start Date:	End Date:	
Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In progress, expected completion date:			
Accredited By: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> RCPSC <input type="checkbox"/> Other:			

Training Type: <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other:			
Name of Hospital:			
Street Address:	City:	State:	Zip:
Affiliated Medical School:			
Department Specialty:	Start Date:	End Date:	
Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In progress, expected completion date:			
Accredited By: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> RCPSC <input type="checkbox"/> Other:			



**EMPLOYMENT/PROFESSIONAL HISTORY**

In chronological order, list all healthcare employment/professional history for the past five years. Attach additional page if necessary. Include the actual work address, not corporate headquarters. If you have not worked in a healthcare position in the past five years check the corresponding box.

I have not worked in a healthcare position in the past five years ___				
Employer	Job Description/Title	Address	Start Date	End Date

**OTHER LICENSES/PERMITS/CERTIFICATIONS**

List all state or jurisdictions in which you currently, or have ever held, a **healthcare related license, permit or certification, permanent or temporary**. If you have never held a healthcare related license, permit or certification in another state or jurisdiction check the corresponding box. The Board will verify your credentials for any state or jurisdiction that provides free and current verifications on their official state website and includes the following information: issue date, expiration date, and any pending or past disciplinary action. If the Board is unable to verify your credentials, you may complete the verification form and forward to all licensing agencies. The Board accepts electronic verification directly from the licensing agency or their official third-party vendor.

I have never held a healthcare related license, permit or certification in another state or jurisdiction ___			
State	Issue Date	License Type	License Number

**PROFESSIONAL LIABILITY INSURANCE & FUND COMPLIANCE**

K.S.A. 40-3402 requires MD, DO, DC, DPM and PAs practicing in Kansas to maintain professional liability insurance of not less than \$200,000 per claim, and not less than \$600,000 annual aggregate for all claims made during the policy period. These professions are also required to maintain compliance with the Kansas Health Care Stabilization Fund (KHCSF). K.S.A. 40-3404; K.S.A. 65-2809(c). Submit one of the following as proof of coverage: Certificate of Compliance from the KHCSF, Certificate of Insurance, or a letter of intent from the liability insurance company or employer. The letter of intent must include the insurance company's information, coverage amounts, and coverage dates. Proof of coverage is not required if attending the University of Kansas School of Medicine – Kansas City or the University of Kansas School of Medicine – Wichita.

I certify that I have read and understand the professional liability insurance and KHCSF requirements and will maintain compliance while I am practicing in Kansas. ___
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**U.S. ARMED FORCES SERVICE**

U.S. Armed Forces Service: ___ Yes ___ No	Branch:	
Start Date:	End Date:	Type of Discharge:



## ATTESTATION QUESTIONS

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.

Full Name of Applicant \_\_\_\_\_

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.\****



**AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION**

**Applicant:** in the presence of a notary public, sign and date this form with attached photo. Email completed form to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail 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 Postgraduate Permit 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 a change occurs 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 to practice medicine.

**Applicant  
Photograph**

Attach a 2 x 3- inch color photograph of applicant, with head and shoulder areas only, taken within the last 90 days.

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

\_\_\_\_\_  
Applicant's printed first name middle initial, last name, 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 \_\_\_\_\_



## LETTER OF COMPLETION

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For the purpose of obtaining a postgraduate permit the Letter of Completion will only be accepted 3 weeks prior to graduation or after graduation, in lieu of an official transcript, when it is confirmed that all degree requirements have been met and the official transcript with the final degree awarded is not yet available.

**Applicant:** Complete the top portion and submit to the school or program.

**School or Program:** This form may be completed **3 weeks prior to graduation or after graduation, in lieu of an official transcript, when it is confirmed that all degree requirements have been met and the official transcript with the final degree awarded is not yet available.** Complete the bottom portion and email to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail directly to the Kansas State Board of Healing Arts. The seal or notary must be clearly visible to be accepted by email.

I hereby authorize the school or program listed below to provide the Kansas State Board of Healing Arts any and all information pertaining to my education at that institution.

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

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

Name of School or Program: \_\_\_\_\_

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

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### TO BE COMPLETED BY THE PRESIDENT, REGISTRAR, DEAN OR DIRECTOR OF COURSE

Name of Applicant: \_\_\_\_\_

Name of School or Program: \_\_\_\_\_

Address: \_\_\_\_\_

Start Date: \_\_\_\_\_ Completion or Expected Completion Date: \_\_\_\_\_

Degree Awarded: \_\_\_\_\_

By signing below, I certify under penalty of perjury under the laws of the State of Kansas that the information provided is a true and correct statement of the record of the above-named applicant. It is further certified that the applicant completed all requirements according to the standard of accreditations prevailing at the time and will receive the above-stated degree.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name & Title

(Seal)

\_\_\_\_\_  
Email



## CERTIFICATION OF POSTGRADUATE TRAINING PROGRAM

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**Applicant:** Complete the top portion and submit to the postgraduate training program.

**Postgraduate Program:** Complete the bottom portion and email to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail directly to the Kansas State Board of Healing Arts. The seal or notary must be clearly visible to be accepted by email.

I hereby authorize the hospital/program listed below to provide the Kansas State Board of Healing Arts any and all information pertaining to my postgraduate training at that institution.

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

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

Name of Hospital or Program: \_\_\_\_\_

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

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**TO BE COMPLETED BY THE PROGRAM DIRECTOR, CLINICAL DIRECTOR, OR TRAINING SUPERVISOR**

Training Type: \_\_\_ Internship \_\_\_ Residency \_\_\_ Fellowship \_\_\_ Research \_\_\_ Other: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ a

Address: \_\_\_\_\_

Affiliated Medical School: \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

Start Date: \_\_\_\_\_ Expected Completion Date: \_\_\_\_\_  
(This will be the expiration date of the permit)

Accredited By: \_\_\_ ACGME \_\_\_ AOA \_\_\_ Other: \_\_\_\_\_

By signing below, I certify under penalty of perjury under the laws of the State of Kansas that the information provided is a true and correct statement of the record of the above-named physician. Furthermore, I certify in event the physician ceases to be engaged in the postgraduate program the Board will be notified within 7 business days.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name & Title

(Seal)

\_\_\_\_\_  
Email



## **FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS**

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A criminal background check is required prior to issuance of licensure. Be aware that fingerprint processing may delay your application. **Please make it a priority to complete the fingerprint process.**

Following is the Waiver Agreement and FBI Privacy Act Statement. Please complete, sign and date the top portion of this form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Please visit <https://www.nbinformation.com/locations/locationMap.php> for a listing of fingerprinting locations.

Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the fingerprints must be printed on the fingerprint card and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or call (785) 296-7413.

Complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submission. Include name, aliases, 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.

Mail the completed Waiver Agreement and fingerprint card to the Board. You may want to use a mailing service that allows for delivery confirmation.

Kansas State Board of Healing Arts  
Attn: Licensing  
800 SW Jackson, Lower Level – Suite A  
Topeka, KS 66612  
Phone: (785) 296-0934  
Email: [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov)

Fingerprint results are valid for 6 months from the date received. Applications for licensure completed after the 6-month period will be required to submit a new Waiver Agreement, fingerprint card, and \$47 fee.

**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. The fingerprints are authorized to be submitted under the authority of the National Childcare Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law 103-209 and Public Law 105-251. 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).)

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**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).

**WAIVER AGREEMENT  
AND  
FBI PRIVACY ACT STATEMENT (Cont.)**

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).

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**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](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

**WAIVER AGREEMENT  
AND  
FBI PRIVACY ACT STATEMENT (Cont.)**

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34). The Authorized Recipient must submit a new set of fingerprints and fee to receive the updated federal criminal history record.

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.

The name, address, and date of birth provided below appear on a valid identification document as defined in Title 28 United States Code, section 1028.

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:	<input type="checkbox"/> Driver's License	<input type="checkbox"/> State Issued ID Card
	<input type="checkbox"/> Military ID Card	
State/Branch: _____	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.***





### 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



## 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: \_\_\_\_\_





## 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.