APPLICATION FOR PODIATRY POSTGRADUATE PERMIT

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. All candidates for licensure or renewal have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application may be subject to the public information laws of this state.

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. 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 name change.

Full Name: _____ (first) _____ (middle) _____ (last) _____ (suffix)

Other names used, including maiden name: _____

2. 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: _____

3. Daytime phone number (include area code): _____

4. 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. K.S.A. 74-139 requires disclosure of 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, 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 of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Such disclosure is for identification purposes only. Your social security number will not be released for any other purpose not permitted by law.

Date of Birth: _____ Place of Birth: _____ (city) _____ (state/jurisdiction) _____ (country) Sex: M ☐ F ☐

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: _____

5. List all Podiatry schools you have attended, even those which you did not graduate. **Attach an additional sheet if necessary.**
Request an official and final transcript showing the degree awarded be sent directly to the Board.

School Name: _____

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Degree: _____
month year month year

6. List all postgraduate programs / preceptorships you have attended, even those that you did not complete.
Attach an additional sheet if necessary.

I have never attended a postgraduate program / preceptorship. ☐

Name of Program: _____ Department/Speciality: _____

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Successfully completed: Yes ☐ No ☐
month year month year

Name of Program: _____ Department/Speciality: _____

Address: _____
street city state zip country

Attendance Dates: _____ To _____ Successfully completed: Yes ☐ No ☐
month year month year

7. List all states or jurisdictions in which you are currently or have ever been licensed, registered or certified as a podiatrist. 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 DPM license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

I have never been licensed, registered or certified in another state or jurisdiction. ☐

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

Applicant Name: _____
please type or print

8. Certificate of Postgraduate program.

It is hereby certified that Dr. _____ has been accepted at
applicant's name

_____ and will be training at _____ in _____
school and/or program's name — name of the Kansas hospital or practice — city

in the department of _____ with a start date of _____ and completion date of
specialty — date - mm/dd/yy

_____ . The program is credentialed by ACGME ☐ AOA ☐ Neither ☐. The applicant will be covered under
date - mm/dd/yy

professional liability insurance and participate in the Kansas Health Care Stabilization Fund as required by Kansas law. (if the program is outside of a Kansas postgraduate program you must provide proof of the malpractice insurance and participation in the Kansas Health Care Stabilization Fund.)

_____ _____ School Seal here
signature — date

_____
title

(if no seal, statement must be notarized by the school)

9. List all employment/professional activities since you have completed podiatry training (school and postgrad training. Account for all time and explain all gaps. Attach an additional sheet if necessary.

☐ None, completed training less than 3 months ago.

Type of Activity: Dates: from (mm/yy) to (mm/yy) Location:

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Application fee of $50 and NPDB Report fee of $3. Make the fees payable to: Kansas Board of Healing Arts or charge by credit/debit card using the attached authorization form.

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 martialed 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 to KSBHA_Licensing@ks.gov or mail it directly to the Kansas State Board of Healing Arts.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the application for Podiatrist licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if a change occurs any time prior to a license to practice Podiatry 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 Podiatry.

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 last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature ***(must correspond to date of notarization)***

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

NOTARY

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

The statements on this document are subscribed and sworn to before me by the applicant on this _____day of _____, 20_____

Notary Public Signature _____ My Notary Commission Expires _____

LICENSE VERIFICATION FORM

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 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:_____

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: _____

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
www.ksbha.org

THIRD PARTY RELEASE

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 or mail it directly to the Board.

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

Kansas State Board of Healing Arts
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GENERAL INFORMATION AND INSTRUCTIONS
Postgraduate Permit - Podiatry
Please visit www.ksbha.org for all information governing a Postgraduate Permits.

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.

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 by 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 additional information or documents to the requirements mentioned herein before the application will be deemed complete to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. Failure to fully disclose could constitute grounds alone for denial of your application. Please avoid some of the common excuses: "My attorney told me I don't have to disclose." or "I did not think the prior act had anything to do with my profession or that it was still on my record or that it happened so long ago." There is no excuse for not disclosing.

Kansas application fees must be submitted with the application, are **NOT** refundable and will be processed upon receipt. The Kansas application fee is $50. 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 debit or credit card please complete the credit card authorization form.

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

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

The National Practitioner Data Bank (NPDB) Report was mandated by Congress and tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. All applicants include a $3 report fee for the Board to obtain the NPDB report.

CHECK LIST - Did you complete the following?

ALL questions answered on the application
Provide documentation for any “Yes” Attestation Questions
Request verification(s) of licenses from states, countries, or jurisdictions, if applicable
Request an official and final transcript from the professional school be sent directly to the board
Request the certificate of postgraduate program be completed by the profession school and submitted directly to the board
Notarize and sign the Affidavit and Authorization for Release with color photo
Documentation of Name change, if applicable
Fee

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

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Email the completed form to 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: ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS ☐ MasterCard	
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.

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