GENERAL INFORMATION PHYSICAL THERAPIST (PT) AND PHYSICAL THERAPIST ASSISTANT (PTA)

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 Physical Therapy in Kansas, please visit Statute and Regulation Handbook.

The application and all forms are fillable PDFs and can be submitted electronically by emailing 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.**

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.

If your license is issued before November 1, you will be required to renew during that year's renewal period. If your license is issued after November 1, you will not be required to renew until the next year's renewal period. Renewal starts November 15; late renewal starts January 1. All PT/PTA licenses expire January 31.

Fees:

Application**: $80**

NPDB: **$3**

Temporary Permit: **$25**

ALL FEES ARE NON-REFUNDABLE

If you:	**Then complete the:**
Never held a Kansas Physical Therapy license	Initial Application
Previously held a Kansas Physical Therapy license that is now cancelled	Reinstatement Application

PT/PTA Application Requirements Check List:

☐	Complete application with all questions answered.
☐	Request official transcript with final PT/PTA degree awarded directly from the school.
☐	Request the Letter of Completion if transcript with final degree is not available. (Temporary permit only)
☐	Request verification of other licenses, permits or certifications, if applicable.
☐	Request electronic verification from FSBPT.
☐	Provide documentation for any "YES" answers to the Attestation Questions.
☐	Notarize and sign the Affidavit and Authorization.
☐	Complete 2021 HB 2066 Questionnaire
☐	Complete jurisprudence exam. (PTs Only)
☐	Complete Accommodations Form, if applicable.
☐	If foreign trained, request a credential evaluation from FCCPT or ICD
☐	If foreign trained, documentation that the language of instruction was English or current TSE/TOEFL certificate.
☐	Provide documentation of name change, if applicable.
☐	Complete and sign the Third-Party Release, if applicable.

For frequently asked questions, visit: http://www.ksbha.org/faq/faqlicensingpt.shtml

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

APPLICATION INSTRUCTIONS – PHYSICAL THERAPIST (PT) AND PHYSICAL THERAPIST ASSISTANT (PTA)

Application Fees: Application fees must be submitted with the application. These *fees are* ***non-refundable*** and will be processed upon receipt. The Kansas PT/PTA application fee is **$80**. Also, a National Practitioner Data Bank ("NPDB") report fee of **$3** must accompany the application. This totals **$83**. Board staff directly runs an NPDB report for all applicants. **Please do not submit an NPDB self-query.** The temporary permit fee is an additional **$25**. 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.

Temporary Permits: Temporary permits are available for applicants who meet the requirements for licensure but have not yet taken the National Physical Therapy Examination ("NPTE"). Only one temporary permit may be issued, and the permit expires three months after the date of issuance. If applying for a temporary permit, a **Letter of Completion** will be accepted in lieu of an official transcript when all degree requirements have been met, and an official transcript is not yet available. The official transcript with final degree awarded must be received by the Kansas Board of Healing Arts ("Board") before a permanent license can be issued.

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. 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.

Examination: List all NPTE examination attempts. Request FSBPT send the Board an electronic official score report by visiting https://www.fsbpt.org/Our-Services/LicenseeServices/ScoreTransferService. **The verification must be received directly from FSBPT.** If you have not tested check the corresponding box and list the date you are scheduled to sit for the exam.

Postsecondary Education: In chronological order, list all postsecondary schools you have attended, even those from which you did not graduate. Attach additional page if necessary. Request an **official transcript with the final PT/PTA 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.

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, it must be clearly visible to be accepted by email. The Letter of Completion must be received directly from the school or program.

Healthcare Employment/Professional History: In chronological order, list all healthcare employment/professional history for the past five years. Attach additional page if necessary. Include 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.

License Designation (PTs Only): Read each description and select the appropriate license designation.

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.

Jurisprudence Exam: Complete the jurisprudence exam and return it with your application. Answers can be found in the Physical Therapy rules and statutes handbook.

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.

Accommodations Request Form: If you are applying to take the exam with Kansas as your jurisdiction and you need special accommodations (i.e. reader, additional time, etc.), before you can be approved to sit for the exam, it will be necessary for you to complete and return this form to the Board and provide the following:

- A statement to the Board advising whether or not special accommodations were granted during your professional education, if so, what type of accommodations were granted. It will also be necessary for your program director to provide a letter advising that accommodations were given, and the type of accommodations provided.
- A letter or report directly from your treating health care provider that includes:
    - Name, title, specialty and credentials of the professional making the diagnosis and accommodation recommendation
    - A diagnosis of the disability pursuant to the ICD, DSM IV or revised or other applicable recognized diagnostic tests
    - Last consultations with the applicants
    - Recommendation for specific accommodations
    - Rationale for requesting the accommodations

Credential Evaluation (Foreign Trained Only): Request a credential evaluation from the Foreign Credentialing Commission on Physical Therapy (FCCPT) or International Consultants of Delaware (ICD).

TOEFL Certificate (Foreign Trained Only): Any applicant who received training at a school where English was not the primary language of instruction shall provide one of the following:

- Official documentation that the primary language of instruction in the physical therapy program was English;
- A current Test of English as a Foreign Language – Internet based testing (TOEFL iBT) certificate in which the applicant has obtained a minimum of the following in each section: Writing 24, Speaking 26, Reading 21, and Listening 18.

PHYSICAL THERAPIST (PT) AND PHYSICAL THERAPIST ASSISTANT (PTA) INITIAL LICENSURE APPLICATION

Completed application and forms can be emailed to 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.**

TYPE OF LICENSURE

Type of license/certificate you are requesting: Physical Therapist (PT) ☐ Physical Therapist Assistant (PTA) ☐
Are you requesting a Temporary Permit? (for applicants who have not yet taken and passed the NPTE) Yes ☐ No ☐

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 ☐	Female ☐

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 No Business address: ☐	Street Address:			
	City:		State:	Zip:
	Phone:	Email:		
Preferred Address: (mailed and emailed correspondence will be sent to the selected address)			Home ☐	Business ☐

LEGAL AUTHORITY TO WORK IN THE U.S.

Are you a US Citizen? ☐ Yes ☐ 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 *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 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.

I do not have an NPI Number ☐	NPI number:

EXAMINATION

List all NPTE examination attempts. Request FSBPT send the Board an electronic official verification of your certification. The verification must be received directly from FSBPT. If you have not tested check the corresponding box and list the date you are scheduled to sit for the exam.

Date Passed:	Number of Attempts:
I have not yet tested ☐	Date scheduled to sit for exam:

POSTSECONDARY EDUCATION

In chronological order, list all postsecondary schools you have attended, **even those from which you did not graduate**. Attach additional page if necessary. Request an official transcript with final PT/PTA 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.

College/University:			
City:	State:	Start Date:	End Date:
Degree Earned:			

College/University:			
City:	State:	Start Date:	End Date:
Degree Earned:			

HEALTHCARE EMPLOYMENT/PROFESSIONAL HISTORY

In chronological order, list all healthcare employment/professional history for the past five years. Attach additional page if necessary**. Include actual work address, not corporate headquarters.** If you have never previously worked in a healthcare position check the corresponding box.

I have not worked in a healthcare position during 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. Attach additional sheet if necessary.

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

LICENSE DESIGNATION

Read each description and select the appropriate license designation.

Active ☐	Engaged in the practice of physical therapy. Required to complete continuing education and maintain professional liability insurance.
Federal Active ☐	Engaged in the practice of physical therapy solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies. Required to complete continuing education. **Not** required to maintain professional liability insurance.
Exempt ☐	Does **not** regularly engage in the practice of physical therapy and does not hold oneself out to the public as being professionally engaged in such practice. Entitled to all the privileges of physical therapy and may serve as a paid employee or unpaid volunteer of (A) A local health department as defined by K.S.A. 65-241 or (B) an indigent health care clinic as defined by K.S.A. 75-6102. Required to complete continuing education. Not required to maintain professional liability insurance.
Inactive ☐	**Not** engaged in the practice of the physical therapy and does not hold oneself out to the public as being professionally engaged in such practice. Required to complete continuing education. **Not** required to maintain professional liability insurance

PRACTICE LOCATION

I plan on practicing in Kansas ☐	I am **NOT** planning on practicing in Kansas ☐

EXPEDITED LICENSURE QUESTIONNAIRE

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

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

   Branch:_____ Dates of Service:_____ Military ID#:_____

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

   Branch:_____ Dates of Service:_____ Military ID#:_____

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

   Current Kansas Residence Address:_____

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

   Intended Kansas Residence Address:_____

   Expected Date of Commencing Residence:_____

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

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

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

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

Organization that issued private certification/registration:_____ Date Issued:_____

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

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

If you answered "yes" to question #6, you do not need to answer question #7.

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

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

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 Physical Therapist or Physical Therapist Assistant Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

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

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

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if a change occurs any time prior to a license to practice Physical Therapy being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license to practice Physical Therapy.

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 _____

KANSAS PHYSICAL THERAPIST JURISPRUDENCE EXAM (PTs Only)

All Physical Therapist: Compete the jurisprudence exam and return it with your application. Answers are available in the Physical Therapy Statute and Regulation Handbook.

_____ _____

Full Name of Applicant Date

1. Which is NOT part of Kansas Statute 65-2901, (hereafter called the Kansas Physical Therapy Practice Act), definition of physical therapy?
    a. Examining, evaluating and testing individuals
    b. Alleviating impairments, functional limitations and disabilities
    c. The practice of any branch of the healing arts
    d. Fabrication of orthotics, debridement and wound care, manual therapy.

2. Which professional designation is not legal for introductions or business cards/public address in Kansas?
    a. Dr. Jane Doe, physical therapist
    b. Jane Doe, PT, DPT
    c. Dr. Jane Doe, DPT
    d. Dr. Jane Doe

3. Which is NOT part of obtaining a temporary permit to practice in Kansas?
    a. Submission of an application on a form sent to the Board of Healing Arts
    b. Meeting all requirements for licensure as a physical therapist (PT), or certification as a physical therapist assistant (PTA)
    c. Payment of a temporary permit fee, which expires three months after date of issue
    d. Obtaining additional temporary permits

4. Which is NOT one of the requirements for licensure renewal applications?
    a. 20 continuing educational hours for PTs and 10 for PTAs every two years.
    b. Notice of conviction of felony, fraud, incompetence, or unprofessional conduct.
    c. Updates to the Board of Healing Arts on correct address and work setting within 30 days of change
    d. Proof of professional liability insurance policy, except for inactive license

5. Which is NOT one of the reasons licenses may be refused or sanctioned, suspended or limited?
    a. Failure to refer patients to other providers if symptoms are beyond physical therapy scope of practice
    b. Addiction to, or distribution of, intoxicating liquors or drugs for other than lawful purposes
    c. Knowingly submitting any deceptive or untrue claim, bill or statement
    d. Treating human beings as authorized by the Kansas Physical Therapy Practice Act

6. Which would NOT be considered unprofessional conduct that results in a sanction of license?
    a. Failing to provide adequate supervision to a PTA or other person who performs services pursuant to delegation by a physical therapist.
    b. Promising a patient a permanent cure for an incurable disease, condition or injury.
    c. Changing jobs too frequently.
    d. Advertising a guarantee of any professional physical therapy service.

7. What is NOT part of the definition of unprofessional conduct?
    a. Charging excessive fees for services performed
    b. Treating two or more patients at one time
    c. Providing treatment unwarranted by the patient's condition or continuing beyond reasonable benefit
    d. Committing any act of sexual abuse or misconduct

8. Supervision of a PTA by a PT includes all of the following EXCEPT:
    a. Notification by the PTA to the Board of Healing Arts of each supervising PT's name and license number
    b. On-site personal supervision of aides, technicians, or paraprofessionals by the PT, or PTA under the direction of the PT, being immediately available to support personnel.
    c. Support personnel may be delegated skilled professional care of patients beyond basic "tasks" if given on-site instructions
    d. Consideration of the education, training, experience and skill level of the physical therapist assistant

9. The Kansas Physical Therapy Practice Act specifically states that the supervising physical therapist must supervise each physical therapist assistant working under his or her direction and supervision. How often must the physical therapist see each patient treated by the physical therapist assistant?
    a. A minimum of every 30 days
    b. A minimum of every two weeks
    c. A minimum of weekly
    d. Neither the Statutes nor the Rules and Regulations specify a specific time frame, except when a PTA initiates treatment after phone consultation with the PT

10. The Kansas State Board of Healing Arts can now impose a fine on a Physical therapist for a first offense not to exceed:
    a. $100
    b. $5,000
    c. $10,000
    d. $500

11. Under the Kansas Physical Therapy Practice Act, which of the following are NOT within the scope of physical therapy practice?
    a. Laser surgery
    b. Anodyne treatment
    c. Electromyography
    d. Nerve conduction velocity testing

12. Physical therapists can evaluate and treat, without a referral from a licensed care professional, in all cases EXCEPT:
    a. Wound debridement
    b. Employees solely for the purpose of work-place injury prevention
    c. Special education students as part of an IEP or IFSP
    d. In a hospital outpatient PT department

13. Physical therapists may evaluate and treat a patient, without a referral from a licensed health care professional, for no more than 10 visits or 15 business days after initial treatment EXCEPT:
    a. Patient was provided written diagnosis that physical therapist cannot make "medical diagnosis"
    b. In a hospital outpatient physical therapy department
    c. Patient has demonstrated objective, measurable or functional improvement
    d. All of the above

14. Which statement is a description of an appropriate activity for a PTA?
    a. Interpretation of a referral, followed by performance and documentation of initial examination, testing, evaluation, diagnosis, and prognosis
    b. Provision of physical therapy treatment interventions following an established plan of care
    c. Development or modification of a plan of care that is based on a reexamination of the patient or client that includes the physical therapy goals for intervention
    d. Documentation of the patient's discharge summary

15. Physical therapists are required to countersign notes written by physical therapists and physical therapist assistants who are working under a temporary permit.
    a. True
    b. False

16. Physical therapists and physical therapist assistants who have temporary permits must have direct supervision by a licensed physical therapist until they pass the appropriate PT or PTA national examination.
    a. True
    b. False

17. According to the Kansas Physical Therapy Practice Act, physical therapists are not allowed to delegate parts of the skilled physical therapy treatment to physical therapy aides.
    a. True
    b. False

18. Physical therapist assistants can write the discharge summary for a patient (e.g., a summary of treatments, patient progress, goals met, prognosis for further increase in function, etc.).
    a. True
    b. False

19. Physical therapists are required to carry malpractice insurance in the amount of 1 million/3 million.
    a. True
    b. False

20. In a sports medicine clinic, it is appropriate for a physical therapist assistant who is also an athletic trainer to evaluate and treat a patient and bill for it as physical therapy.
    a. True
    b. False

21. If I know a physical therapist or physical therapist assistant is practicing unethically or illegally, and do nothing about it, I am in violation of the Kansas Physical Therapy Practice Act.
    a. True
    b. False

22. According to Kansas Rules and Regulations, it would be considered unprofessional conduct for a PTA to allow his/her patients to refer to him/her as “my physical therapist”.
    a. True
    b. False

23. It is unprofessional conduct for a physical therapist or a physical therapist assistant to refer a patient or a client to a health care entity for services if the PT or PTA has a significant investment interest in the health care entity, unless the patient/client is informed in writing of the significant investment interest and that the patient/client can obtain services elsewhere.
    a. True
    b. False

24. The PT Advisory Council currently consists of three PTs, a physician, and a member of the Kansas State Board of Healing Arts.
    a. True
    b. False

25. Physical therapists may provide services without a referral to special education students who need physical therapy services to fulfill the provisions of their individualized education plan or individualized family service plan.
    a. True
    b. False

PHYSICAL THERAPIST (PT) AND PHYSICAL THERAPIST ASSISTANT (PTA) ACCOMMODATIONS REQUEST FORM

If you are applying to take the exam with Kansas as your jurisdiction and you need special accommodations (i.e. reader, additional time, etc.), before you can be approved to sit for the exam, it will be necessary for you to complete and return this form to the Board. Email the completed form and supporting documentation to KSBHA_Licensing@ks.gov or mail directly to the Kansas State Board of Healing Arts. KSBHA recommends applicants to make and keep copies of forms submitted to the Board.

Name: _____

Address: _____

Phone Number: _____ Email: _____

Describe the Nature of your disability and include specific diagnosis:

When was your disability first diagnosed: _____

How does your disability affect your ability to take examinations?

What accommodations are you requesting during the examination?

What accommodations (if any) have you received in the past for the following exams:

- ☐ National Physical Therapy Exam
- ☐ College Exams
- ☐ Standardized Exams (e.g., SAT, ACT)
- ☐ Other: _____

In addition to this form, provide the following:

- A statement to the Board advising whether or not special accommodations were granted during your professional education, if so, what type of accommodations were granted. It will also be necessary for your program director to provide a letter advising that accommodations were given, and the type of accommodations provided.
- A letter or report (no more than 3 years old) directly from your treating health care provider that includes:
  - A diagnosis of the disability pursuant to the ICD, DSM IV or revised or other applicable and recognized diagnostics tests
  - Last Consultation with the applicant
  - Recommendation for specific accommodations
  - Rationale for requesting the accommodations

_____ _____

Signature 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

LETTER OF COMPLETION

For the purpose of obtaining a temporary license, the Letter of Completion may be submitted 3 weeks prior to graduation or any time 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: For the purpose of obtaining a temporary license, this form may be completed **3 weeks prior to graduation or any time 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 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: _____

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

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
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

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

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.

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