



**STATE BOARD OF HEALING ARTS**

800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612

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**QUERY ORDER FORM**

**Organization:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip** \_\_\_\_\_

**REQUESTED FORMAT:**

The File will be in an Excel spreadsheet: ( ) Email - \$45

**(PLEASE SUBMIT THE REQUIRED PAYMENT WITH THIS FORM)**

**QUERY OPTIONS (please check all boxes you are requesting for your report)**

**Licenses**

- |  |  |
|--|--|
| <input type="checkbox"/> (AT) Athletic Trainer                   | <input type="checkbox"/> (MD) Medical Doctor Exempt              |
| <input type="checkbox"/> (AT) Athletic Trainer Inactive          | <input type="checkbox"/> (MD) Medical Doctor Inactive            |
| <input type="checkbox"/> (DC) Chiropractic Doctor                | <input type="checkbox"/> (MD) Medical Doctor Federal Active      |
| <input type="checkbox"/> (DC) Chiropractic Doctor Exempt         | <input type="checkbox"/> (ND) Naturopathic Doctor                |
| <input type="checkbox"/> (DC) Chiropractic Doctor Inactive       | <input type="checkbox"/> (OT) Occupational Therapist             |
| <input type="checkbox"/> (DC) Chiropractic Doctor Federal Active | <input type="checkbox"/> (OTA) Occupational Therapy Assistant    |
| <input type="checkbox"/> (DO) Osteopathic Doctor                 | <input type="checkbox"/> (PA) Physician Assistant                |
| <input type="checkbox"/> (DO) Osteopathic Doctor Exempt          | <input type="checkbox"/> (PA) Physician Assistant Inactive       |
| <input type="checkbox"/> (DO) Osteopathic Doctor Inactive        | <input type="checkbox"/> (PA) Physician Assistant Federal Active |
| <input type="checkbox"/> (DO) Osteopathic Doctor Federal Active  | <input type="checkbox"/> (PT) Physical Therapist                 |
| <input type="checkbox"/> (DPM) Podiatric Doctor                  | <input type="checkbox"/> (PT) Physical Therapist Inactive        |
| <input type="checkbox"/> (DPM) Podiatric Doctor Exempt           | <input type="checkbox"/> (PTA) Physical Therapy Assistant        |
| <input type="checkbox"/> (DPM) Podiatric Doctor Inactive         | <input type="checkbox"/> (RT) Respiratory Therapist              |
| <input type="checkbox"/> (DPM) Podiatric Doctor Federal Active   | <input type="checkbox"/> Institutional                           |
| <input type="checkbox"/> (LRT) Radiologic Technologist           | <input type="checkbox"/> Postgraduate Permit                     |
| <input type="checkbox"/> (MD) Medical Doctor                     | <input type="checkbox"/> Contact Lens                            |

**Sort Order:**

- Alpha
- County
- License
- Zip Code
- Other

**Requested Fields:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Address (mailing)  | <input checked="" type="checkbox"/> Phone Number (business) | <input type="checkbox"/> Disciplinary Action (Y/N)                                  |
| <input type="checkbox"/> Address (business) | <input type="checkbox"/> Year of Birth                      | <input type="checkbox"/> Specialty (MD/DO Only) (please list specialty/specialties) |
| <input type="checkbox"/> County (mailing)   | <input type="checkbox"/> License Number                     | <input type="checkbox"/> License Type/Status/Military                               |
| <input type="checkbox"/> County (business)  | <input type="checkbox"/> Degree Date                        | <input type="checkbox"/> e-mail address   |
| <input type="checkbox"/> Phone Number       | <input type="checkbox"/> Original License Date              |   |
| <input type="checkbox"/> (mailing)          | <input type="checkbox"/> License Expiration Date            |   |

**To order:** submit this form by e-mail or fax.

**YOU MUST CERTIFY ONE OF THE FOLLOWING:**

( ) Neither you nor any person within your organization intends to, and will not: (A) Use any list of names or addresses contained in or derived from the records or information for the purpose of selling or offering for sale any property or service to any person listed or to any person who resides at any address listed; and will not (B) sell, give or otherwise make available to any person any list of names or addresses contained in or derived from the records or information for the purpose of allowing that person to sell or offer for sale any property or service to any person listed or to any person who resides at any address listed; OR

( ) You have a statutory right of access to the records, and the basis of that right is: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of person signing