APPLICATION FOR DUPLICATE CERTIFICATE

Please enter required information, sign and date at the bottom. Print and mail with any required documentation.

Name: First Middle Last

Mailing Address: Street City State Zip

Telephone Number: - -

E-Mail Address:

Hereby certify that I was originally issued and currently hold license / registration number to practice in the State of Kansas. -

Reason for the Request for a Duplicate Certificate:

☐ Additional Locations ☐ Name Change* ☐ Lost ☐ Stolen ☐ Mutilate

☐ Destroyed ☐ Other (specify):

*If you indicated name change, the original certificate **MUST** be returned along with the name change application.*

Fee: $15.00

Please make your check payable to the KANSAS STATE BOARD OF HEALING ARTS

For payment by credit/debit card, please complete and return the credit card authorization form.

I certify under penalty of perjury under the laws of the State of Kansas that the information provided on this form, including supporting documentation is true and correct and that I am licensed/registered to practice in the State of Kansas.

Signature Date