Print Form

Kansas

APPLICATION FOR CHANGE OF DESIGNATION/TYPE

Please enter required information, sign and date on the bottom of page 2.
E-mail form with required documentation and credit card form to
KSBHA_Licensing@ks.gov

License No. _____ - _____ ☐ Medicine & Surgery ☐ Chiropractic ☐ Osteopathic ☐ Podiatry

Current Type: ☐ Active ☐ Federal Active ☐ Military ☐ Exempt ☐ Inactive

Name: _____ _____ _____
First Middle Last

Home Address: _____ _____ _____ _____
Street City State Zip

Home Telephone Number: _____ - _____ - _____ E-Mail Address: _____

Business Address: _____ _____ _____ _____
Street City State Zip

Business Telephone Number: _____ - _____ - _____ E-Mail Address: _____

Preferred Mailing Address: ☐ Home ☐ Business

EFFECTIVE _____ / _____ / _____ The effective date **CANNOT be a retroactive date** and must be a date in the future from the date the Board receives your request.

I request a license type change to:(check the license type below)

Please select only **ONE** type.

☐ **Active:** A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

1. List in chronological order all professional activities since your license was last Active or initially issued if the license was never Active (use additional pages if necessary):

From:MO/YR To:MO/YR	Complete Address	Position Held

2. If rendering any professional services in Kansas, you are required by law to maintain professional liability insurance of not less than $200,000 per claim, $600,000 annual aggregate, and participate in the Kansas Health Care Stabilization Fund (KHCSF). You must provide proof that your professional liability insurance is in compliance. Proof of insurance may be a notice of coverage, certificate of insurance or notification of insurance binder from your agent. Non-residents must submit a copy of their non-resident certificate form. If you have any questions about participation with KHCSF call please (785) 291-3777.

3. If your continuing education is not current, proof of your continuing education hours must be included with your application. You may verify your continuing education year by reviewing your wallet card or visiting our website www.ksbha.org,

4. Since the last renewal date of your Kansas license, have you:

☐ Yes ☐ No had an adverse judgment, award, or settlement resulting from a professional liability claim?
☐ Yes ☐ No had a disciplinary action taken or initiated against you by a state licensing agency or surrendered or consented to limitation of your license to practice in any state?
☐ Yes ☐ No had any hospital privileges suspended?
☐ Yes ☐ No been found guilty or pled no contest to a felony or Class A misdemeanor?

Attach documentation and an explanation if your answer is "yes" to any of the above questions.

☐ **Federal Active:** A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practices that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration, and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

1. Location of Federal Employment: _____
Name of Employer Street City State Zip

2. If your continuing education is not current, proof of your continuing education hours must be included with your application. You may verify your continuing education year by reviewing your wallet card or visiting our website www.ksbha.org.

3. List in chronological order all professional activities since your license was last Active or initially issued if the license was never Active (use additional pages if necessary):

From:MO/YR To:MO/YR	Complete Address	Position Held

4. Since the last renewal date of your Kansas license, have you:

☐ Yes ☐ No had an adverse judgment, award, or settlement resulting from a professional liability claim?
☐ Yes ☐ No had a disciplinary action taken or initiated against you by a state licensing agency or surrendered or consented to limitation of your license to practice in any state?
☐ Yes ☐ No had any hospital privileges suspended?
☐ Yes ☐ No been found guilty or pled no contest to a felony or Class A misdemeanor?

Attach documentation and an explanation if your answer is "yes" to <u>any</u> of the above questions.

☐ **Exempt:** A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

I intend to engage in the following professional activities in Kansas:

☐ Consultant ☐ Charitable Health Care Provider ☐ Administration
☐ Treatment of Family and Friends with No Compensation ☐ Coroner/Deputy Coroner ☐ None
☐ Other: _____

☐ **I acknowledge by marking the check box, with an exempt license I will not be a health care provider as defined by K.S.A. 40-3401, that I am not required to maintain professional liability insurance in accordance with K.S.A. 40-3401 and that services I render while a holder of an exempt license will not be insured or covered by the Health Care Stabilization Fund.**

☐ **Inactive:** A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

Fees: Please complete the credit card authorization form or make your check payable to Kansas State Board of Healing Arts.

Current Type of	
	Active or Federal Active changing to any type: No Fee
	Military changing to Active or Federal Active: $330
	Military changing to Exempt or Inactive: $150
	Exempt or Inactive changing to Exempt or Inactive: No Fee
	Exempt or Inactive changing to Active or Federal Active: $175

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 to practice in the State of Kansas.

Signature _____ Date _____

Print Form

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Please enter required information, sign and date at the bottom. Email or Mail form.

☐ DISCOVER NETWORK ☐ MasterCard ☐ AMERICAN EXPRESS ☐ VISA

CARD NUMBER

Verification Code

3-4 digit non-embossed number found on the card signature panel

Expiration Date

MO / YR

Name (as it appears on the credit card): _____

Billing Address: _____ _____ _____ _____
Street City State Zip

Telephone Number: _____ - _____ - _____

Payment Amount $ _____ Purpose of Payment: _____
(e.g. renewal, application)

Applicant/Licensee Name: _____

I agree to pay the above amount per the card issuer agreement.

_____ _____
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

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