



**STATE VERIFICATION FORM for ATs**

Please enter required information, sign and date at the bottom. E-mail, mail or fax form.  
There is **no** charge for verifications.

Full Name: \_\_\_\_\_

Other Names Used (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

License or Registration No.: \_\_\_\_\_ - \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Profession: \_\_\_\_\_

I hereby authorize and request the Kansas Board of Healing Art to furnish information regarding my license or registration including documents and/or records regarding charges or complaints filed against me or my license/registration; formal, informal, pending, closed or any other pertinent information to:

Agency \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature: \_\_\_\_\_ Date : \_\_\_\_\_