



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 : _____