Kansas

AD ASTRA PER ASPERA

REINSTATEMENT APPLICATION FOR ATHLETIC TRAINER

Completion of this application form is necessary for consideration for licensure. Disclosure of this information is voluntary; however, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for licensure or renewal have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application may be subject to the public information laws of this state.

Please type or print. When space provided is insufficient, attach additional pages. You may reproduce these blank forms as needed. Please make sufficient copies of all forms before you begin.

1. Kansas License no:_____________

2. Indicate your full legal name. If your name is different from that shown on your documentation you must submit a copy of the legal document of the name change. If your name is different from your Kansas license you will need to complete the *Name Change* form. You can download the form from our website or call to have mailed.

Full Name: ____
first middle last suffix

Other names used, including maiden name:______________________________

3. Include residence, mailing and e-mail address. Residence address may *not* be a Post Office Box, except qualified participants under the Safe At Home Act, K.S.A. 75-451 *et seq.* may use substitute residential and mailing addresses.

Residence Address: ____
street city county state zip

Mailing Address: ____
public information
street city county state zip

E-mail: ____

4. Daytime phone number (include area code):__________________________

5. Identification. Disclosure of your social security number is required by federal mandates set forth in 42 U.S.C.S. § 666(a)(13). K.S.A. 74-148(a) provides that every application by an individual for a professional license shall require the applicant's social security number. K.S.A. 74-139 requires disclosure of your social security number upon request to the Kansas director of taxation. Your social security number may be provided for child support enforcement actions, to the Kansas director of taxation, for reporting disciplinary actions to the National Practitioner Data Bank-Health Integrity and Protection Data Bank (NPDB-HIPDB) as required by 45 C.F.R. §§ 61.1 *et seq.* Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Such disclosure is for identification purposes only. Your social security number will not be released for any other purpose not permitted by law.

Social Security/Tax ID. No: ________________

NPI (National Provider Identifier): ______________ NPI Not Applicable: ☐

Are you a U.S. Citizen? Y ☐ N ☐ If you answered NO, are you (check one):

A qualified alien (as defined in 8 U.S.C.A. § 1641). ☐

A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 *et seq)*. ☐

An alien who is paroled into the United States under 8 U.S.C.A. § 1182(d)(5) for less than one year. ☐

A foreign national, not physically present in the United States. ☐

Other: ____

6. List all professional activities since the time of cancellation of your Kansas license. Account for all time and explain all gaps in professional activity. Attach an additional sheet if necessary. List actual work location.

Activity:________________________________ Employer (if applicable) ______________________________

Location:____________________________________ Dates: From ____________ To ____________
street city state

Activity:________________________________ Employer (if applicable) ______________________________

Location:____________________________________ Dates: From ____________ To ____________
street city state

Activity:________________________________ Employer (if applicable) ______________________________

Location:____________________________________ Dates: From ____________ To ____________
street city state

Activity:________________________________ Employer (if applicable) ______________________________

Location:____________________________________ Dates: From ____________ To ____________
street city state

7. List all states, countries or jurisdictions in which you are currently or have been licensed, registered or certified in any health care profession. Attach an additional sheet if necessary. You must complete the attached *Licensure Verification* form and forward to all Boards or similar entities in which you have held any health care license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

I have never been licensed, registered or certified in another state,country or jurisdiction. ☐

State/Country/Jurisdiction	License, Registrant, Certificate no.	Status	Issue Date
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

8. Recommendation by a peer that has known the applicant for a minimum of 1 year.

I ______________________________, a licensed and/or practicing athletic trainer in the state of ____________
(name, please print) (state name)

affirms that ______________________________ has been known to me for ______ year(s), and that applicant, to
(name of applicant)

the best of my knowledge is an ethical practitioner, is of good professional character, and not addicted to the use of alcohol or drugs.

______________________________ ______________________________
signature address

______________________________ ______________________________
date city, state and zip

Applicant Name: ________________________
(please print or type)

9. Please answer each of the following questions by putting a check in the appropriate box. All "yes" answers MUST be thoroughly explained in detail on a separate signed page. You are required to furnish complete details including date, place, reason and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant. If you are unsure of your response to a particular question, check the "yes" box and submit the appropriate form if required. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check the "no" box.

(a) Yes ☐ No ☐ Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training?

(b) Yes ☐ No ☐ Have you ever had any application for any professional license refused or denied by any licensing authority?

(c) Yes ☐ No ☐ Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?

(d) Yes ☐ No ☐ Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

(e) Yes ☐ No ☐ Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

(f) Yes ☐ No ☐ Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?

(g) Yes ☐ No ☐ Have you ever voluntarily surrendered any professional license?

(h) Yes ☐ No ☐ Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held?

(i) Yes ☐ No ☐ Have you ever been notified or requested to appear before a licensing or disciplinary agency?

(j) Yes ☐ No ☐ To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?

(k) Yes ☐ No ☐ Has any professional association imposed any disciplinary action against you?

(l) Yes ☐ No ☐ Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?

(m) Yes ☐ No ☐ Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?

(n) Yes ☐ No ☐ Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?

(o) Yes ☐ No ☐ Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?

(p) Yes ☐ No ☐ Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?

(q) Yes ☐ No ☐ Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?

(r) Yes ☐ No ☐ Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?

(s) Yes ☐ No ☐ Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?

(t) Yes ☐ No ☐ Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

(u) Yes ☐ No ☐ Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

(v) Yes ☐ No ☐ Have you ever been court martialed or discharged dishonorably from the armed services?

(w) Yes ☐ No ☐ Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself?

(x) Yes ☐ No ☐ Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?

(y) Yes ☐ No ☐ Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company?

Additional information, reference question letter and include date, place, reason and disposition of the matter. Attach all relevant legal documentation.

____

____

____

____

____

____

Applicant Name: ______________________________
(please print or type)

10. Photo.

Attach a **2"x3" wallet size** photograph of applicant with head and shoulder areas only. The photograph must have been taken within 90 days prior to date of application. Proof photographs, negatives, copies of photographs, poor quality, photographs cut from books, newspaper articles or passport photos are **NOT** accepted.

11. Oath must be signed by applicant and notarized.

I, ____________________________________, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice as an athletic trainer in the state of Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years of each violation (K.S.A. 21-3805).

____
Signature of Applicant

Sworn to before me this _______________ day of

______________________________ 20______

SEAL

______________________________ Notary Public

______________________________ Commission Expires

12. Notarized copy of an active BOC certification or a copy of continuing education certificates as required by KAR 100-69-11 if applicable.

13. Notarized copy of a current first aid certification.

14. License Designation. Please select the license designation you are requesting

☐ ACTIVE: A license issued to a person engaged in the practice of athletic training. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and as a condition of providing services as an athletic trainer in this state that constitute the practice of the healing arts, each athletic trainer licensed by the board shall file a practice protocol with the board on a form issued by the board. Each active license may be renewed annually.

☐ INACTIVE: A license issued to a person who meets all the requirements for a license to practice as an athletic trainer and who does not actively practice in this state. Each inactive license may be renewed annually and must submit evidence of satisfactory completion of a program of continuing education.

15. Fee of $80.00.
Make the fee payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

Applicant Name: ______________________________
(please print or type)

revised 3-30-12, kl

Authorization and Release

Must be signed by applicant and notarized.

I,____ , hereby authorize all hospitals, institutions or organization, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Kansas Board of Healing Arts or its successors any information, files or records requested by the Board in connection with this application. I further authorize the Kansas State Board of Healing Arts or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure.

____
Signature of Applicant

SEAL

Sworn to before me this ____________day of

___________________________ 20 _____

___________________________ Notary Public

___________________________ Commission Expires

800 SW Jackson, Lower Level-Suite A., TOPEKA KS 66612
Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

GENERAL INFORMATION AND INSTRUCTIONS
Athletic Trainer
Please visit http://www.ksbha.org/statutes/booklets/athletictrainers.pdf
for all information governing an Athletic Trainer License.

Please read the following information very carefully. This information is vital to the successful completion of your application. Often your questions are covered in this form. Please allow two (2) weeks after the submission of the application before contacting our office. Do not make a commitment to any work dates prior to being licensed.

All applicants are considered on an individual basis. You may be requested to submit information or documents in addition to the requirements mentioned herein before the application will be deemed complete. It is highly recommended you make and keep copies, for your records, of all items submitted for review. In addition, when mailing you may want to request a delivery confirmation to confirm your application has been received at the Kansas Board of Healing Arts.

Kansas Application Fees must be submitted with the application and are **NOT** refundable. Kansas application fee is $80.00. Make checks payable to KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card and include a $30.00 processing fee. To pay by debt or credit card please complete the credit card authorization form.

You must submit any change of address to the Board. Please visit our website to complete the "Change of Address" form.

Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to the Kansas Board of Healing Arts.

Licenses/Certificates expire December 31 and are renewed annually. License renewal will be required of all receiving a permanent license prior to September 1.

CHECK LIST
Did you complete the following?

ALL questions answered on the application
Request verification from states, countries or jurisdictions if applicable
Signature of recommendation #8
Documentation to any “YES” answers to #9
Head and shoulder photograph (size: **2X3** taken within 90 days of application)#10
Sign and have notarized Oath #11
Sign and have notarize Release Form
Notarized copy of the BOC certification or a copy of continuing education certificates if applicable #12
Notarized copy of a current first aid certification #13
Completed Protocol
Application payment

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Kansas

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CREDIT CARD PAYMENT AUTHORIZATION

Please enter required information, sign and date at the bottom. Mail or fax 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)

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.

office use only

revised 1-25-11, kl

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STATE VERIFICATION FORM

Send to all states in which a license or registration has ever been issued. Verification fees may be applicable and are the applicant's responsibility. Please contact individual boards to confirm fees. The applicant should complete the top section. The official state board should complete the bottom section and return directly to the Kansas State Board of Healing Arts.

I, hereby authorize and request the state Board of ______________________________ having control of any documents, records and other information pertaining to me to furnish to the Kansas State Board of Healing Arts information 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.

Full Name: ______________________________

Other Names Used (if applicable): ____________________ Date of Birth: ______ / ______ / ______

License or Registration No.: ____________________ Issue Date: ______ / ______ / ______

Profession: ______________________________

Signature: ____________________ Date: ____________________

Full Name of licensee or registrant: ______________________________

License or Registration No.: ____________________ Status: ____________________

Issue Date: ______ / ______ / ______ Expiration Date: ______ / ______ / ______

License Method: ____________________ School: ____________________

DISCIPLINARY ACTIONS:

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? ☐ Yes ☐ No ☐ Unable to Divulge

Have formal disciplinary proceedings been initiated against the applicant or applicant's license or registration by a disciplinary authority in your state? ☐ Yes ☐ No ☐ Unable to

Comments ______________________________

(SEAL)

Signature ____________________

Title ____________________

State Board of ____________________

Date ____________________

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for active license only

ATHLETIC TRAINER'S RESPONSIBLE PHYSICIAN and PROTOCOL

Please enter required information, sign and date at the bottom of the page. Mail or fax form.

Athletic Trainer's Name: ______________________________

Responsible Physician's Name:: ______________________________

Under my supervision, the above designated Athletic Trainer will have the authority to act in my behalf and provide the following care

	YES	NO
Perform evaluations, emergency care, and transportation.	☐	☐
Perform the application of preventative and protective measures designed to prevent injuries or protect existing injuries including taping, padding bandaging, dressing skin wounds and splinting	☐	☐
Initiate standard treatment procedures of applying cold, compression, elevation and rest to injured body parts.	☐	☐
Application of cryotherapy such as cold/ice packs, cold water immersion, ice massage and spray coolants.	☐	☐
Application of thermotherapy such as topical analgesics, moist hot packs, heating pads, infrared heat, and paraffin baths.	☐	☐
Application of hydrotherapy such as whirlpool and contrast bath.	☐	☐
Application of therapeutic exercise common to athletic training such as stretching, conditioning, strengthening, and muscle testing.	☐	☐
Application of additional clinical contemporary therapeutic modalities including patient preparation, set up, determination of dosage and treatment such as but not limited to diathermy (shortwave, microwave, ultrasound) and muscle stimulation.	☐	☐
Application of rehabilitation procedures for post operative injuries and non-operative injuries.	☐	☐
Act as an advisor concerning diet, rest, hydration, hygiene, sanitation, injury/illness prevention, and physical fitness development.	☐	☐

______________________________ Signature of Responsible Physician and Date

______________________________ Signature of Athletic Trainer and Date

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