

**Kansas State Board of Healing Arts**  
235 S. Topeka Blvd.  
Topeka, KS 66603-3068

Phone: 785/296-7413  
Toll Free: 888/886-7205  
www.ksbha.org



Dear Doctor:

The Board of Healing Arts is pleased that you have chosen to apply for licensure in Kansas. This packet contains all the materials you will need to complete your application for licensure.

**Uniform Application for Physician State Licensure (UA):**

The Board has incorporated the Uniform Application for Physician State Licensure (UA) into its medical licensing application. This form will make it easier for physicians to apply for licensure in states that utilize this form (UA). The Kansas State Board of Healing Arts is one of a growing number of boards to incorporate the UA into its state application.

**The Federation Credentials Verification Service (FCVS):**

The Board **accepts** the use of FCVS to primary source verify core physician credentials as part of the licensure process. If using FCVS, the Board recommends completing the FCVS application first or simultaneously with the Kansas State Board of Healing Arts application for licensure.

FCVS is a service of the Federation of State Medical Boards (FSMB) and was created to help license portability for physicians. FSMB is a national not-for-profit organization that provides this service for state medical and osteopathic medical licensing authorities in the United States, Guam, Puerto Rico and the Virgin Islands. Contact FCVS for a complete state listing of requiring and accepting licensing authorities, or go to <http://www.fsmb.org/fcvs.html>

By using FCVS to verify your credentials, you will establish a permanent repository of primary source-verified documents. Once your file is established, these documents will be available for your use at any time. The documents that FCVS verifies and stores for you fall into the following categories:

- Identity
- Medical Education
- Postgraduate Training
- Examination History (state licensing authorities only)
- Board Action/Disciplinary History
- ECFMG Certification (if applicable)
- ABMS Board Certification

You pay FCVS a fee for gathering and forwarding your Initial or Subsequent Profile, and can also forward additional profiles to other licensing boards and health care entities of your choice. Average processing time to collect and forward your Initial Profile is approximately 8-12 weeks. Once your permanent file is established, updated Subsequent Profiles are typically forwarded within 2-3 weeks. Most physicians will benefit greatly throughout their career by having their credentials permanently stored and easily accessible.

Contact FCVS at 888-ASK-FCVS (or outside the U.S. at 1-817-868-5000) for additional information regarding the service and its fees or go to <http://www.fsmb.org/fcvs.html>. If your credentials are already on file with FCVS, contact FCVS directly at the above number to have them forwarded to the Kansas State Board of Healing Arts.

Sincerely,

Kansas State Board of Healing Arts



**Kansas State Board of Healing Arts  
235 S. Topeka Blvd.  
Topeka, KS 66603-3068  
785-296-7413**

**GENERAL INFORMATION AND INSTRUCTIONS FOR  
MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)**

Please visit [www.ksbha.org](http://www.ksbha.org) for all statutes and regulations

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.

Kansas does not have direct reciprocity with any state. 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 State Board of Healing Arts. Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to the Kansas State Board of Healing Arts. Do not send original forms or documentation to the Board.

**Application Fee:** Kansas application fee: \$300.00. Kansas application fee must be submitted with the application and is **NOT** refundable. You may pay by check, debit card, Visa, MasterCard, Discover, American Express or money order. 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, debit card or credit card and include a \$30.00 processing fee.

**Examination Requirements & Test Scores:** Accepted examinations are National Boards (NBME, NBOME), FLEX, USMLE, State Examinations, LMCC, COMLEX, or a combination of FLEX, USMLE, and National Boards. Applicants who took the FLEX prior to June 1985 must have passed the examination with a FLEX weighted average of 75 or higher, attained in one sitting. Applicants who took the USMLE must complete all steps within 10 years.

Request that a transcript of your test scores be sent directly to the Kansas State Board of Healing Arts by contacting the appropriate agency. **If you are using FCVS, they will obtain your test scores and send them to the Board.** For those that have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), you must request the transcripts from the NBME.

- ◆ **USMLE/FLEX/SPEX** – Request transcripts online at [www.fsmb.org/transcripts.html](http://www.fsmb.org/transcripts.html). For questions or assistance, please call (817) 868-4041 or email: [usmle@fsmb.org](mailto:usmle@fsmb.org)
- ◆ **NBME** – Download the request form at [www.nbme.org/programs-services/medical-students/tabs/certifications-transcripts.html](http://www.nbme.org/programs-services/medical-students/tabs/certifications-transcripts.html). For questions or assistance, please call (215) 590-9500 or email: [scores@nbme.org](mailto:scores@nbme.org)
- ◆ **NBOME/COMLEX** – Call (773) 714-0622. For questions or assistance, visit their website at [www.nbome.org](http://www.nbome.org) or email: [transcripts@nbome.org](mailto:transcripts@nbome.org)
- ◆ **State Exam** – Contact the state licensing board in which you took the exam
- ◆ **LMCC** – Call (613) 521-6012

**National Practitioner Data Bank Report:** Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank (NPDB). This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. **The Kansas State Board of Healing Arts will obtain a NPDB report for all applicants. Applicants will be required to submit the report fee of \$9.50 to the Board.**

**AMA and AOIA Reports:** Request the AMA report from the American Medical Association at <https://profiles.ama-assn.org/amaprofiles/> or call 800-665-2882. Request the AOIA report from the American Osteopathic Information Association at <https://www.doprofiles.org> or call 800-621-1773 x8145.

**Notarized Documents:**

- ◆ **Medical School Diploma:** Applicants must submit a notarized copy of their medical school diploma(s) to the Kansas State Board of Healing Arts. The diploma(s) must be notarized as a true and accurate copy of the original. Note: Diplomas in languages other than English must be translated and the translation certified as accurate. Documents without such certification will not be accepted.
- ◆ **ECFMG Certificate (if applicable):** Applicants must submit a notarized copy of their ECFMG Certificate to the Kansas State Board of Healing Arts. The certificate must be notarized as a true and accurate copy of the original.

**International Medical Graduates/ECFMG:** All international medical graduates must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and provide evidence of completion of three (3) years of postgraduate training with at least two (2) of those years completed in the USA. Postgraduate training must occur after graduation. Request that a “Status Report of ECFMG Certification” be sent directly to the Kansas State Board of Healing Arts. Download the request and payment forms at [www.ecfm.org/cvs/stbrd.html](http://www.ecfm.org/cvs/stbrd.html) or call 215-386-5990. **If you are using FCVS, you do not need to contact the ECFMG. FCVS will coordinate with the ECFMG to obtain your certification.**

**License Renewals:** MD licenses expire on June 30 and are renewed annually. License renewal will be required of all MD applicants receiving permanent licenses prior to April 1. DO licenses expire on September 30 and are renewed annually. License renewal will be required of all DO applicants receiving permanent licenses prior to July 1.

**Veridoc:** You can request verification of many state licenses through Veridoc at [www.veridoc.org](http://www.veridoc.org) or call 701-319-6500.

**Please Note:** Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. If you do not utilize a Livescan agency, you must request a fingerprint card from the Board **785-296-7413** or **888-886-7205**. Please visit our website at [www.ksbha.org](http://www.ksbha.org) for a listing of Livescan agencies. Be aware that fingerprint processing may delay your application. Please make it a **PRIORITY** to complete the fingerprint process.

## INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)

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**Application Instructions** - Complete the board application (UA pages 1-20). Please type or print. All sections must be completed to the best of your knowledge. For those items which do not apply to you, mark N/A (not applicable). If additional space is needed to respond to any question on the application, you may attach separate pages in continuation of the Board application. Such pages MUST clearly indicate the section for which such information is being reported. Please see additional instructions below for completing specific sections of the Uniform Application for Physician State Licensure (UA).

- ◆ **ECFMG (Page 7) (if applicable):** In addition to having a certified “Status Report of ECFMG Certification” sent directly to this board, **applicants must also submit a notarized copy of their ECFMG Certificate to the Kansas State Board of Healing Arts. The certificate must be notarized as a true and accurate copy of the original.**
  
- ◆ **Malpractice Liability Claims Information (Page 10):** For all malpractice claims include a written statement from the insurance company or insurance/personal/institution attorney. Include date of occurrence, name of the insurance company involved on your behalf, name of claimant(s), other defendant(s) and/or institution involved, list of all attorneys involved, case number and location of filing, status of the matter, and summary of the occurrence; or you may provide court documents. Failure to provide complete information will result in delay of processing the application.
  
- ◆ **Affidavit and Authorization for Release of Information (Page 11):** Please read this form carefully. Attach a recent (less than 6 months old) two inch by two inch (2” x 2”) passport-type color photograph of yourself in the space provided. This form must be notarized. Please note that by signing this Affidavit and Authorization for Release of Information form, you agree to the following...

**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 medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry in the state of Kansas and may subject me to a fine not exceeding \$10,000 and term of imprisonment not exceeding 5 years for each violation. (K.S.A. 21-3805)**

- ◆ **Medical School Verification (Page 13):** Complete Sections 1 and 2 of this form then send this form to your medical school. Request the Dean or designated official to complete Section 3 of this form and return this form and a copy of your official transcripts directly to this Board. **The Kansas State Board of Healing Arts does not require the medical school to send a sealed copy of your diploma to them. If you are using FCVS, do not complete this form. Your medical school verification will be collected by FCVS as part of your FCVS Physician Profile.**

**Addendum 1 (Addendum Page 1)** - These questions must be completed by the applicant. Return this form to the Board along with the completed application.

**Addendum 2 (Addendum Pages 2 and 3)** - Each question must be completed by the applicant. Documentation must be provided for any “yes” answer(s). Return this form to the Board along with the completed application.

**Addendum 3 (Addendum Pages 4 and 5)** - The applicant’s full name and date of birth should be printed in the spaces provided on both pages. Two (2) recommendations by licensed physicians that can attest to the applicant’s good moral character, and who have known the applicant for at least one year are required. The completed forms must be **returned directly to the Board**. Two (2) forms have been provided for your convenience.

**Addendum 4 (Addendum Page 6)** - This form needs to be completed by the applicant. All applicants for licensure in the State of Kansas must request a disciplinary inquiry report from the Federation of State Medical Boards (FSMB). Once this form has been completed, it should be mailed to the FSMB at the address indicated below. **If you are using FCVS, do not complete this form. They will obtain your disciplinary report and send it to the Board.**

BOARD ACTION DATABANK INQUIRY  
FEDERATION OF STATE MEDICAL BOARDS  
PO BOX 619850  
DALLAS, TX 75261-9850

**Addendum 5 (Addendum Pages 7 and 8)** – Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. Addendum 5 explains in detail how to obtain and submit this information to the Board.

**CHECK LIST:  
Did you complete the following?**

- \_\_\_\_\_ I have completed the FCVS application and submitted all required forms, documents, and fee directly to FCVS (**if applicable**).
- \_\_\_\_\_ I have enclosed a payment of **\$300.00** for the Kansas application fee.
- \_\_\_\_\_ I have enclosed a payment of **\$9.50** for the National Practitioner Data Bank Report.
- \_\_\_\_\_ Kansas Board Application:
  - \_\_\_\_\_ I have answered **ALL** questions on the board application (**UA pages 1-20**).
  - \_\_\_\_\_ I have completed the **Affidavit and Authorization for Release of Information Form** (UA page 11). I have attached a color photograph of myself and the form has been notarized by a notary public.
  - \_\_\_\_\_ I have completed **Addendum 1**.
  - \_\_\_\_\_ I have completed **Addendum 2** and provided documentation for any “yes” answers.
  - \_\_\_\_\_ I have requested two (2) professional recommendations by licensed physicians that I have known for at least one year using the forms provided in **Addendum 3**.
  - \_\_\_\_\_ I have requested a Board Action Databank report by completing **Addendum 4** and mailing the form to the Federation of State Medical Boards.
  - \_\_\_\_\_ I have completed and signed the **Waiver Agreement and Statement Form** provided in **Addendum 5**.
- \_\_\_\_\_ Verification Requests:
  - \_\_\_\_\_ Licensure Verification (UA page 12)
  - \_\_\_\_\_ Medical School Verification (UA pages 13-16). **If using FCVS, they will obtain this.**
  - \_\_\_\_\_ Postgraduate Training Verification (UA pages 17-19). **If using FCVS, they will obtain this.**
  - \_\_\_\_\_ Fifth Pathway Verification (if applicable, UA page 20). **If using FCVS, they will obtain this.**
- \_\_\_\_\_ Additional Documents:
  - \_\_\_\_\_ I have requested a transcript of my test scores. **If using FCVS, they will obtain this.**
  - \_\_\_\_\_ I have requested the AMA or AOIA report.
  - \_\_\_\_\_ I have requested the ECFMG Certification report (**if applicable**).
  - \_\_\_\_\_ I have submitted a notarized copy of my ECFMG Certificate to the Board (**if applicable**).
  - \_\_\_\_\_ I have submitted a notarized copy of my medical school diploma(s) to the Board.
  - \_\_\_\_\_ I have submitted my fingerprint card along with a **\$49.00** background check fee (**\$50.00 if received after 9-30-09**) to the Board. **Do Not** combine the background check fee with the application fee.
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# CREDIT CARD PAYMENT AUTHORIZATION FORM

Please print or type.



### CARD NUMBER

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### 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 12-18-07 k1

## Application for Physician Licensure Instructions

### Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. There are two different checklists below; one when you are using the Federation Credentials Verification Service (FCVS) and one when you are not using FCVS. Please use the checklist that applies to you.

	State does not require FCVS and you choose not to use FCVS	State requires or accepts FCVS and you are using FCVS
Completed Application (including state addendums)	<input type="checkbox"/>	<input type="checkbox"/>
State Licensure Verification form sent to the Board from all states in which you have ever held any healthcare license	<input type="checkbox"/>	<input type="checkbox"/>
Enclose the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	<input type="checkbox"/>	<input type="checkbox"/>
Notarized copy of birth certificate or current, valid passport	<input type="checkbox"/>	completed via FCVS
Medical Education Verification form sent to the Board by all medical schools attended – include a copy of your diploma (must be sealed by your school)	<input type="checkbox"/>	completed via FCVS
Medical school transcripts sent to the Board by your medical school	<input type="checkbox"/>	completed via FCVS
Fifth Pathway (if applicable) form sent to the Board from the medical school and institution – include a copy of your diploma (must be sealed by your school)	<input type="checkbox"/>	completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended	<input type="checkbox"/>	completed via FCVS
Enclose a copy of your postgraduate training certificate with this application when submitting it to the Board	<input type="checkbox"/>	completed via FCVS
Examination transcripts sent to the Board	<input type="checkbox"/>	completed via FCVS
ECFMG (if applicable) Status Report sent to the Board	<input type="checkbox"/>	completed via FCVS

**It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.**

## Application for Physician Licensure

**1. Name:** Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

### 1. Full Name (use no initials)

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Suffix \_\_\_\_\_

Maiden Name \_\_\_\_\_

M.D.  D.O.

\_\_\_\_\_  
All other names used

**2. Address/Phone:** Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore, you should consider what your preferred address is for these purposes.

#### Practice Address

Public Access

Mailing

Street \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail address \_\_\_\_\_

Alternate Phone (e.g. pager or cell phone) \_\_\_\_\_

#### Home Address

Public Access

Mailing

Street \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail address \_\_\_\_\_

Alternate Phone (e.g. pager or cell phone) \_\_\_\_\_

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Uniform Application for Physician State Licensure

**3. Identification:** If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

**3. Identification**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date of Birth                      Birth City                      Birth State/Province                      Birth Country  
(mm/dd/yyyy)

\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_                      Are you a U.S. Citizen?     Yes     No  
Gender                      Social Security Number                      NPI Number

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to <http://www.cms.hhs.gov/NationalProvIdentStand/>.

**4. Medical School:** List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

**4. Medical School** (attach additional pages if necessary)

1. School Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Country \_\_\_\_\_  
Attendance Dates (From – To) \_\_\_\_\_  
Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

2. School Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Country \_\_\_\_\_  
Attendance Dates (From – To) \_\_\_\_\_  
Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**5. Fifth Pathway:** If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

**5. Fifth Pathway (if applicable)**

1. Medical School Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

Attendance Dates (From – To) \_\_\_\_\_

Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

2. Medical School Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

Attendance Dates (From – To) \_\_\_\_\_

Graduation Date \_\_\_\_\_ Degree \_\_\_\_\_

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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**6. Postgraduate Training:** List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

**6. Postgraduate Training** (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1. Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

PGY: (e.g., 1, 2, 3, etc.)  Internship  Residency  Fellowship  Research  Other

Accredited by:  ACGME  AOA  RCPSC  None  Other \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Successfully Completed? Yes  No  In Progress   
 Month Year Month Year

2. Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

PGY: (e.g., 1, 2, 3, etc.)  Internship  Residency  Fellowship  Research  Other

Accredited by:  ACGME  AOA  RCPSC  None  Other \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Successfully Completed? Yes  No  In Progress   
 Month Year Month Year

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**6. Postgraduate Training (continued)**

3.Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

PGY: (e.g., 1, 2, 3, etc.)  Internship  Residency  Fellowship  Research  Other

Accredited by:  ACGME  AOA  RCPSC  None  Other \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Successfully Completed? Yes  No  In Progress   
Month Year Month Year

4.Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Country \_\_\_\_\_

PGY: (e.g., 1, 2, 3, etc.)  Internship  Residency  Fellowship  Research  Other

Accredited by:  ACGME  AOA  RCPSC  None  Other \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ Successfully Completed? Yes  No  In Progress   
Month Year Month Year

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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**7. Examination History:** If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

**7. Examination History**

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
State Board Exam	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
State	_____			
FLEX Pre-1985	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
FLEX Component 1	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
FLEX Component 2	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
LMCC – Single	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
LMCC – Part I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
LMCC – Part II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBME Part I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBME Part II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBME Part III	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
SPEX	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBOME Part I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBOME Part II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
NBOME Part III	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
COMLEX-USA Level 1	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
COMLEX-USA Level 2, CE	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
COMLEX-USA Level 2, PE	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
COMLEX-USA Level 3	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
COMVEX	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
USMLE Step I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
USMLE Step II, CS	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
USMLE Step II, CK	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____
USMLE Step III	_____	<input type="checkbox"/> P	<input type="checkbox"/> F	_____

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**8. ECFMG:** If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG website at [www.ecfm.org](http://www.ecfm.org).

**8. ECFMG** (if applicable)

Certificate Number \_\_\_\_\_ Issue Date \_\_\_\_\_ Valid Through Date \_\_\_\_\_

**9. State/Province Professional Licensure** whether temporary or permanent: List all states and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license or certification. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states or provinces in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

**9. State Licensure – MD or DO only – attach additional pages if necessary**

1. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
2. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
3. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
4. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
5. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
6. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
7. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
8. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
9. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)
10. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_  
(MD, DO)

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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**All Other Health Care Licensure/Certification** (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_
2. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_
3. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_
4. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_
5. State/Province \_\_\_\_\_ Type \_\_\_\_\_ License Number \_\_\_\_\_ Status \_\_\_\_\_ Issue Date \_\_\_\_\_

**10. Chronology of Activities:** List ALL activities (medical, non-medical and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. For any non-working time, you **MUST** state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address. If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

**10. Chronology of Activities** (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____
2. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Dates: From/To	Practice/Employment
3. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____
4. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____
5. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____
6. From: Month: _____ Year: _____  To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above)  Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment <input type="checkbox"/> Staff Privileges <input type="checkbox"/> Affiliation <input type="checkbox"/> Other _____

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_



**Affidavit and Authorization for Release of Information:** You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

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**Affidavit  
And  
Authorization For Release of Information**

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

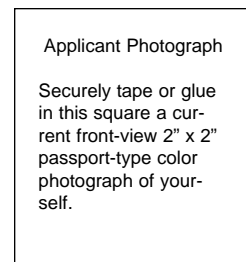
I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

\_\_\_\_\_  
Applicant's Signature (must be signed in the presence of a notary)

\_\_\_\_\_  
Applicant's Printed Last Name

\_\_\_\_\_  
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

\_\_\_\_\_  
Date of Signature



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**NOTARY**

Dated \_\_\_\_\_ Signed \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of, \_\_\_\_\_ 20\_\_\_\_.

My commission expires: \_\_\_\_\_ (NOTARY PUBLIC SIGNATURE & SEAL)

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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_



**Medical School Verification – Page 1 of 4**

(Copy this form for multiple schools)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

**Section 1: Applicant Information**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the medical school below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Section 2: Instructions to the Dean or designated official of medical school**

Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an official copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Board Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Medical School Verification – Page 2 of 4

(Copy this form for multiple schools)

Section 3: Medical School Verification

Medical School Name: \_\_\_\_\_

School name if different when the above applicant attended: \_\_\_\_\_

Medical School Address: \_\_\_\_\_

Street City State/Province ZIP Code

Hours of undergraduate education required for admission into your school: \_\_\_\_\_

Applicant's Attendance Dates: From \_\_\_\_\_ To \_\_\_\_\_ Graduation Date: \_\_\_\_\_ Degree: \_\_\_\_\_

(Indicate N/A if not applicable) (Indicate N/A if not applicable)

Total weeks of education applicant attended your school: \_\_\_\_\_

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

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

Print name: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE

Title: \_\_\_\_\_

(If no seal is available, this form must be notarized)

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

Phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

**Medical School Verification – Page 3 of 4**

(Copy this form for multiple schools)

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response  YES  NO

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			<input type="checkbox"/>	<input type="checkbox"/>
Academic remediation			<input type="checkbox"/>	<input type="checkbox"/>
Health			<input type="checkbox"/>	<input type="checkbox"/>
Financial			<input type="checkbox"/>	<input type="checkbox"/>
Participation in joint degree program (e.g., MD/PhD)			<input type="checkbox"/>	<input type="checkbox"/>
Participation in non-research special study (e.g., fellowship, international experience)			<input type="checkbox"/>	<input type="checkbox"/>
Participation in non-degree research			<input type="checkbox"/>	<input type="checkbox"/>
Other			<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____				

2. Does this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response  YES  NO

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
<input type="checkbox"/> Academic Probation		
<input type="checkbox"/> Probation for unprofessional conduct/behavioral reasons		
<input type="checkbox"/> Probation for other reason		
Please specify reason: _____		

3. Does this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response  YES  NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): \_\_\_\_\_  
 \_\_\_\_\_

**Medical School Verification – Page 4 of 4**

(Copy this form for multiple schools)

4. Does this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response  YES  NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

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5. Does this individual's official records reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

Response  YES  NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

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**Postgraduate Training Verification - Page 1 of 3**

(Copy this form for multiple programs)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your training program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

**Section 1: Applicant Information**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Section 2: Instructions to the PROGRAM DIRECTOR or designated official of POSTGRADUATE TRAINING PROGRAM.**

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board at the following address:

Board Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Postgraduate Training Verification - Page 2 of 3

(Copy this form for multiple programs)

Section 3: Postgraduate Training Verification

Institution Name: \_\_\_\_\_

Institution Address: \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP Code \_\_\_\_\_

Affiliated Medical School Name: \_\_\_\_\_

Program Type/Specialty: \_\_\_\_\_

Postgraduate Year: \_\_\_\_\_

- Internship
- Residency
- Fellowship
- Research
- Chief Resident

Other: \_\_\_\_\_

From Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ To Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Successfully Completed?:  Yes  No  In Progress  
 (The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  RCPSC  APPAP  None of these

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her training?  Yes  No

Was this individual ever placed on probation?  Yes  No

Was this individual ever disciplined or placed under investigation?  Yes  No

Were any negative reports for behavioral reasons ever filed by instructors?  Yes  No

Were any limitations or special requirements placed upon this individual because  Yes  No

of questions of academic incompetence, disciplinary problems or any other reason?

Please explain any "Yes" response from above (attach additional pages if necessary): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Postgraduate Training Verification - Page 3 of 3**

(Copy this form for multiple programs)

***I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.***

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

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

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

Phone number: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**AFFIX INSTITUTIONAL SEAL HERE** (If no seal is available, this form must be notarized)

If you completed Section 5 of the application, you must complete this form  
**Fifth Pathway Verification**

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to the director of your 5th Pathway Program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director’s recommendation letter directly to this Board.

**Section 1: Applicant Information**

Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Name if different when diploma awarded: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

The applicant’s social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

\_\_\_\_\_  
Applicant’s Signature Date

**Section 2: Instructions to the PROGRAM DIRECTOR or designated official**

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board at the following address:

Board Name: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State/Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

**Section 3: Medical School Verification**

Medical School Name: \_\_\_\_\_  
School name if different when the above applicant attended: \_\_\_\_\_  
Applicant’s Attendance Dates: From \_\_\_\_\_ To \_\_\_\_\_ Program Completion Date: \_\_\_\_\_  
(Indicate N/A if not applicable)

***I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.***

Signature: \_\_\_\_\_  
Print name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_

**AFFIX INSTITUTIONAL SEAL HERE**  
(if no seal is available, this form must be notarized)

# Kansas State Board of Healing Arts

## Addendum 1

### Discipline applying for: (Check appropriate item)

Medicine & Surgery       Osteopathic Medicine & Surgery

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### License Designation: Please select the license designation you are requesting.

- 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.
- 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 practiced 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.
- 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.
- 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. List intended professional activities: \_\_\_\_\_
- 

### Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas?     Yes     No
2. Give location of intended practice in Kansas \_\_\_\_\_
3. Primary Specialty \_\_\_\_\_  
American Board Certified \_\_\_\_\_ American Board Eligible \_\_\_\_\_

### Statement of Health:

4. Do you presently have any physical or mental problems or disabilities which could effect your ability to competently practice your particular branch of the healing arts or your particular specialty?  
 Yes     No

If yes, applicant shall file with this application, a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

Name (Printed or typed): \_\_\_\_\_ Date: \_\_\_\_\_

# Kansas State Board of Healing Arts

## Addendum 2

Please answer each of the following questions by putting a check (✓) in the appropriate box. All “yes” answers MUST be thoroughly explained in detail in 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.

1. 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 or educational program, including but not limited to medical school, prior to completing the training?  
Yes No
2. Have you ever had any application for any professional license refused or denied by any licensing authority?  
Yes No
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?  
Yes No
4. 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?  
Yes No
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?  
Yes No
6. 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?  
Yes No
7. Have you ever voluntarily surrendered any professional license?  
Yes No
8. 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?  
Yes No
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency?  
Yes No
10. 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?  
Yes No
11. Has any professional association imposed any disciplinary action against you?  
Yes No
12. 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?  
Yes No
13. 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?  
Yes No

14. 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?  
Yes   No
15. 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?  
Yes   No
16. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?  
Yes   No
17. 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?  
Yes   No
18. Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?  
Yes   No
19. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?  
Yes   No
20. 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.  
Yes   No
21. 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.  
Yes   No
22. Have you ever been court-martialed or discharged dishonorably from the armed services?  
Yes   No
23. 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?  
Yes   No
24. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs?  
Yes   No
25. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs?  
Yes   No

Name (Printed or typed): \_\_\_\_\_ Date: \_\_\_\_\_

**ADDENDUM 3**

**Kansas State Board of Healing Arts**

235 S. Topeka Blvd.  
Topeka, Kansas 66603-3068

***Recommendations From Two Reputable Physicians***

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or typed): \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Please mail this document to the Kansas State Board of Healing Arts at the address shown above.  
Thank you. DO NOT RETURN TO APPLICANT.**

This is to certify that I have known Dr. \_\_\_\_\_ (type or print)  
for \_\_\_\_\_ years; that he/she is a capable physician and is not addicted to alcohol or narcotics.

I further certify that to the best of my knowledge and belief Dr. \_\_\_\_\_ is a  
fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

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

Street 1: \_\_\_\_\_

Street 2: \_\_\_\_\_

State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

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

**ADDENDUM 3**

**Kansas State Board of Healing Arts**

235 S. Topeka Blvd.  
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**Please mail this document to the Kansas State Board of Healing Arts at the address shown above.  
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(Please type or print)

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

Street 1: \_\_\_\_\_

Street 2: \_\_\_\_\_

State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

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

## ADDENDUM 4

### Kansas State Board of Healing Arts

235 S. Topeka Blvd.  
Topeka, KS 66603-3068  
785-296-7413

### Board Action Databank Inquiry Form

All Applicants for licensure by endorsement or examination in the State of Kansas must **COMPLETE THIS FORM AND FORWARD IT TO THE FEDERATION OF STATE MEDICAL BOARDS** for a disciplinary inquiry report.

**BOARD ACTION DATABANK INQUIRY  
FEDERATION OF STATE MEDICAL BOARDS  
PO BOX 619850  
DALLAS, TX 75261-9850  
(817) 868-4008**

**FEDERATION:** Please indicate on the lower portion of this form if any final written orders or finding of fact, have been filed against the individual whose name is listed below. Return it to the state board as indicated.

---

Applicant's Last Name

---

First Name

---

Middle Name

---

Degree (MD, DO or PA only)

---

Date of Birth

---

Medical School

---

Year of Graduation

---

Social Security Number

---

ECFMG# (if applicable)

---

Applicant's Signature

**You must  
check this  
box**

I hereby certify that I am the individual referenced above and I acknowledge that I have answered all questions and reported all information on this page truthfully and completely.

## ADDENDUM 5



### INSTRUCTIONS FOR REQUESTING A CRIMINAL BACKGROUND CHECK

Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks.

Following is the *Waiver Agreement and Statement*. Please complete, sign and date the *Waiver Agreement and Statement* form with your application. Your application will not be deemed as complete without a completed and signed *Waiver Agreement and Statement* form.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. Your local law enforcement agency should be willing to assist you with completing the fingerprints. Some enforcement agencies offer electronic scanning (Livescan). Please visit our website at [www.ksbha.org](http://www.ksbha.org) for a listing of Livescan agencies. Have at least one form of picture identification for the law enforcement agency to examine.

If you do not utilize a Livescan agency, contact the Board at 785-296-7413 or 888-886-7205 to receive a fingerprint card.

Please complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submitting the fingerprint card. Be sure to include name (including aliases, maiden and previous names), complete mailing address, social security number, citizenship, date of birth, and personal information (sex, race, height, weight, eyes, hair, place of birth). The spaces for OCA, FBI and MNU numbers can be left blank. Cards with missing or incomplete information will be rejected and must be resubmitted. Sign the card in front of the law enforcement officer. If you use Livescan, the agency may have a different form for you to complete.

Make a check or money order (do not send cash) payable to the Kansas State Board of Healing Arts for **\$50**. Do Not combine the background check fee with the application fee. A fingerprint card submitted without a separate check or money order for the background check fee of **\$50** will not be processed.

Provide the law enforcement officer with a stamped envelope addressed to KSBHA, 235 SW Topeka Blvd, Topeka, KS 66603 to mail your fingerprint card or electronic scan, and fee. In addition, you may want to use a mailing service that allows for delivery confirmation to confirm your fingerprint card and payment have been received at the Board. Bent and folded cards will not be accepted and a new fingerprint card will be mailed to you for prints to be taken again.

A background check is valid for three (3) months. Applications for licensure completed after the three (3) month period will be required to submit a new fingerprint card for a new clearance.

Any and all resubmissions of fingerprint cards require a **\$50** submission fee to process. Resubmitted fingerprint cards will not be processed without the enclosed fee.

Please complete, sign and return the *Waiver Agreement and Statement* form with your application. Your application will not be deemed as complete without a completed and signed *Waiver Agreement and Statement* form.

235 SW TOPEKA BLVD., TOPEKA KS 6603  
Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: [www.ksbha.org](http://www.ksbha.org)

