



**5. ECFMG.** Applicable for all international medical graduates. Enclose the ECFMG report and a copy of your notarized ECFMG certificate.

Not Applicable

Certificate Number: \_\_\_\_\_

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

**6. List all medical schools you have attended, even those which you did not graduate in chronological order.** Attach an additional sheet if necessary. Enclose or send an **official and final** transcript showing the degree awarded and English translation if applicable.

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

Address: \_\_\_\_\_  
street city state zip country

Attendance Dates: \_\_\_\_\_ To \_\_\_\_\_ Degree: \_\_\_\_\_  
month year month year

**7. List all postgraduate programs you have attended, even those that you did not complete. You must submit a notarized copy of your program of completion for each program completed.** Attach an additional sheet if necessary.

I have never attended a postgraduate program

Internship  Residency  Fellowship  Research  Other

Name of Program: \_\_\_\_\_ Department/Speciality: \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip country

Attendance Dates: \_\_\_\_\_ To \_\_\_\_\_ Successfully completed: Yes  No   
month year month year

Internship  Residency  Fellowship  Research  Other

Name of Program: \_\_\_\_\_ Department/Speciality: \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip country

Attendance Dates: \_\_\_\_\_ To \_\_\_\_\_ Successfully completed: Yes  No   
month year month year

**8. List all states, 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/Jurisdiction License, Registrant, Certificate no. Status Issue Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant Name: \_\_\_\_\_  
(please print or type)

**9. List all activities (medical and nonmedical) in chronological order since medical school graduation. For any nonwork time, you must state what your activities were (e.g. vacation, seeking employment). Attach an additional sheet if necessary.**

Month/Year	Month/Year	Location	Activities
_____	To _____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**10. Certificate of Employment must be completed and signed by director of the practice facility.**

I, \_\_\_\_\_ Director of \_\_\_\_\_ at  
director's name name of hospital, insstitution or medical care facility

\_\_\_\_\_,  
address, city, county, state and zip

hereby, certify that the above named applicant will be in my employ and under contract from \_\_\_\_\_  
date

to \_\_\_\_\_. I further certify that such physician will be under my direction and that if at any time during the  
date

continuation of such licensure the physician shall sever their connectin with my institution, that the Board of Healing Arts will be notified immediately

\_\_\_\_\_  
signature

\_\_\_\_\_  
title

\_\_\_\_\_  
date

**11. 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.



Applicant Name: \_\_\_\_\_  
(please print or type)

12. 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. A 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 martialled 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?
- (y) Yes  No  Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs?

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

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Applicant Name: \_\_\_\_\_  
 (please print or type)

**13. 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 medicine and surgery or osteopathic medicine and surgery 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

**15. Fee of \$200.00.**

**Make the fee payable to: Kansas Board of Healing Arts or charge by credit/debit card using the attached authorization form.**

If you are rendering professional services in the state of Kansas, you are required by K.S.A. 40-3401 - 3419 to maintain professional liability insurance of not less than \$200,000 per occurrence subject to not less than \$600,000 annual aggregate for all claims made during the policy period and to participate in the Kansas Health Care Stabilization Fund. Proof of liability insurance must be provided at the time of renewal.

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](http://www.ksbha.org)

Applicant Name: \_\_\_\_\_  
(please print or type)



**Authorization and Release**

Must be signed by applicant and notarized.

I, \_\_\_\_\_, hereby authorize all hospitals, institutions or organizations, 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

Sworn to before me this \_\_\_\_\_ day of

\_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_ Notary Public

\_\_\_\_\_ Commission Expires

SEAL



GENERAL INFORMATION AND INSTRUCTIONS  
INSTITUTIONAL LICENSE IN MEDICINE AND SURGERY

Please visit [www.ksbha.org](http://www.ksbha.org)  
for all information governing an Institutional 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.

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, are **NOT** refundable and will be processed upon receipt. The Kansas application fee is \$200.00. 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.

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, on 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.

To obtain the ECFMG report visit [www.ecfm.org](http://www.ecfm.org) or call 215-386-5900.

Effective January 1, 2009, healing arts applicants will be required to submit their fingerprints for state and national criminal background checks. Please refer to Instruction for Requesting a Criminal Background check.

### CHECK LIST

#### Did you complete the following?

<b>ALL</b> questions answered on the application	ECFMG report and notarized certificate if applicable
Request official/final transcript and English translation if applicable	Notarized copy of certificate of program completions
Request verification from states or jurisdictions if applicable	Complete certificate of employment #10 by employer
Head and shoulder photograph (size: <b>2X3</b> taken within 90 days of application)#11	Documentation to any "YES" answers to #12
Notarize and sign Oath #13	Notarize and sign Release Form
Application payment	NPDB fee
Finger print submission fee	Signed Waiver Agreement and Statement
Completed fingerprint card or Livescan print out and have mailed to the Board	Criminal background report waiver





**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 Divulge

Comments \_\_\_\_\_

(SEAL)

Signature \_\_\_\_\_  
Title \_\_\_\_\_  
State Board of \_\_\_\_\_  
Date \_\_\_\_\_



## 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 completed 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 Board of Healing Arts for **\$50**. **Do Not** combine the background check fee with the application fee. A finger print card submitted without a separate check or money order for the background check fee will not be processed.

**Provide the law enforcement officer with a stamped envelope addressed to KSBHA800 SW Jackson, Lower Level - Suite A., Topeka, KS 66611 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 six (6) months.** Application for licensure completed after the six (6) month period will be required to submit a new fingerprint card for a new clearance.

Any and all resubmissions of fingerprints 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



## WAIVER AGREEMENT AND STATEMENT

### Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize the Kansas State Board of Healing Arts to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the Purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, the Kansas State Board of Healing Arts may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the Kansas State Board of Healing Arts of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Kansas State Board of Healing Arts may choose to deny my application or grant me a limited or restricted license until the criminal history background check is completed.

I understand that, upon my request, the Kansas State Board of Healing Arts will provide me a copy of the criminal history background report, if any. I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before the Kansas State Board of Healing Arts makes a final decision about my application for a license to practice the healing arts.

I have \_\_\_\_\_ OR have not \_\_\_\_\_ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

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Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 3805, and may result in the denial of my application pursuant to K.S.A. 65-2836 (a).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

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

\_\_\_\_\_  
Residential Address                      City                      State                      Zip