Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Suite A
Topeka, KS 66612

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

KANSAS LICENSURE APPLICATION INSTRUCTIONS
MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Application

Review the following instructions carefully before completing the application. This information is vital to the successful completion of your application. Failure to submit all required information and documentation will result in processing delays. 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 documentation 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. Do not send original forms or documentation to the Board.**

In completing the application, you will be asked to account for all time since medical school graduation and list all **Malpractice Liability Claims Information**. Having this information on hand before you begin your session will facilitate completing your application.

If you have any questions about the information provided to you in the application packet, please contact our office at 785/296-7413. Thank you for applying for licensure in the State of Kansas.

The Federation Credentials Verification Service (FCVS)

The Board accepts the use of FCVS as part of the licensure process. FCVS staff creates a permanent profile of primary source verified documents related to identity, medical education, postgraduate training, and more. The profile can be updated as needed and sent to boards and other entities without the need to verify each item again.

Applicants using FCVS to verify their credentials are still required to complete the Kansas State Board of Healing Arts Uniform Application (UA). If you do not use FCVS, you must provide your credentials to the Board for verification along with completing the UA.

For clarification, the Uniform Application (UA) is used to apply for state licensure. The FCVS application is used only to create or update a personalized profile of primary source verified credentials for use in the overall licensing process.

To use FCVS, visit https://www.fsmb.org/fcvs/ and select "FCVS" in the Licensure or Sign In menu, then sign in and continue as directed. Users with existing FCVS profiles should complete a Subsequent FCVS Application to ensure the profile is up to date. New FCVS users should complete the Initial FCVS Application. All users must, during the application process, designate the Kansas State Board of Healing Arts to receive the FCVS profile. Self designations are not accepted.

More information about FCVS is available at https://www.fsmb.org/fcvs/. For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT on weekdays.

The Uniform Application for Physician State Licensure (UA)

This packet contains a version of the UA that can be completed and mailed to the Board instead of completing the UA online. There is no fee for using the paper UA.

Please note the following:

- The Board requires that you submit your valid National Provider ID number in the space provided.
- 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 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.
- List all professional licenses (nurse, EMT, physician assistant, etc.) you have held in the U.S. or Canada, regardless of status (active, inactive, etc.). If you hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper to the Board. Use the Licensure Verification form in this packet to request license verifications from each board.
- On the Chronology of Activities, for military or locum tenens assignments, list each location/assignment separately. Additionally, for military service, please provide a copy of your discharge or separation documents.
- For all locations where you have had admitting privileges, check the "Staff Privileges" box.
- 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.

In addition to completing the core UA, all applicants must:

- Complete the state addendum.
- Submit a notarized UA Affidavit and Authorization for Release of Information form to the Board. This is a separate form from the FCVS Affidavit and must be sent to the Kansas State Board of Healing Arts. 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. Proof photos, negatives, and digital photos are not acceptable.

  Please note that by signing the 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)

- KSBHA will verify each of your medical board licenses except for any board that does not provide free, current verifications and disciplinary actions on their official website. For those boards, use the licensure verification resource at https://www.fsmb.org/uniform-application/to determine the fees and preferred verification method of each board. Use the Licensure Verification form in this packet for boards requiring a written request. You may use VeriDoc or another preferred method if applicable.

If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education, Postgraduate Training, or Fifth Pathway Verification forms, or send identity documents, transcripts, certificates, or examination scores to the Board. FCVS obtains this information and sends it to the Board as part of your FCVS profile of verified credentials.

If you are not using FCVS for credentials verification,

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if your name is not the same on all of your submitted documents.

- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form.

- Submit a notarized copy of your medical school diploma(s). 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.

- Contact each appropriate examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at http://www.fsmb.org/uniform-application/ua-faq/.

- International Medical Graduates: Submit a notarized copy of your ECFMG Certificate to the Board. It must be notarized as a true and accurate copy of the original. Also request that a "Status Report of ECFMG Certification" be sent directly to the board. If you attended a Fifth Pathway Program, request that the Fifth Pathway Program Certificate be sent to the Board. See the UA FAQ link above for contact information.

Additional Licensure Information / Requirements

- **Application Fee.** The Kansas application fee is $300.00. It 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.

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

- **Criminal Background Report.** 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 your fingerprints to the Board. **Be aware that fingerprint processing may delay your application. Please make it a PRIORITY to complete the fingerprint process. Complete, sign and return the *Waiver Agreement and Statement* form directly to the Board.**

- **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 $3.00 to the Board.**

- **License Renewals.** MD licenses expire on July 31 and are renewed annually. License renewal will be required of all MD applicants receiving permanent licenses prior to May 1. DO licenses expire on October 31 and are renewed annually. License renewal will be required of all DO applicants receiving permanent licenses prior to August 1.

UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE CHECKLIST

After completing the Uniform Application, you are responsible for submitting certain documents. There are two checklists below; one to use if you are using the Federation Credentials Verification Service (FCVS) and one to use if you are not using FCVS. Please use the checklist that applies to you.

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed online Uniform Application (UA).	☐	☐
Completed state addenda and fees (licensure fee of $300 plus National Practitioner Data Bank Report fee of $3) sent to the Board.	☐	☐
Notarized UA Affidavit and Authorization for Release of Information form sent to the Board.	☐	☐
UA Licensure Verification form sent to the Board from each state board through which you have ever held any physician license if KSBHA is unable to verify the license.	☐	☐
American Medical Association or American Osteopathic Information Association report sent to the Board from the AMA or AOIA.	☐	☐
Fingerprint card.	☐	☐
Notarized copy of birth certificate or current, valid passport sent to the Board.	☐	Completed via FCVS
Supporting documentation of any legal name change sent to the Board.	☐	Completed via FCVS
Medical Education Verification form sent to the Board from all medical schools attended.	☐	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school(s).	☐	Completed via FCVS
Notarized copy/copies of medical school diploma sent to the Board.	☐	Completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended.	☐	Completed via FCVS
Copy of your postgraduate training certificate(s) sent to the Board.	☐	Completed via FCVS
Fifth Pathway form (if applicable) sent to the Board from the medical school and institution - include a copy of your diploma (must be sealed by your school).	☐	Completed via FCVS
Examination Transcripts sent to the Board.	☐	Completed via FCVS
ECFMG Status Report (if applicable) sent to the Board.	☐	Completed via FCVS
Notarized copy of ECFMG Certificate (if applicable) sent to the Board.	☐	Completed via FCVS

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KANSAS
BOARD OF HEALING ARTS

KANSAS LICENSURE APPLICATION ADDENDUM INSTRUCTIONS
MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Addendum

Complete each addendum as instructed. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Kansas State Board of Healing Arts at the address above.

☐ **Addendum 1** These questions must be completed by the applicant.

☐ **Addendum 2** Each question must be completed by the applicant. Documentation must be provided for any "yes" answer(s). **It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

☐ **Addendum 3** 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** This form must 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, you may email it to the FSMB at boardinquiry@fsmb.org.

If you are using FCVS, do not complete this form. They will obtain your disciplinary report and send it to the Board.

☐ **Addendum 5** 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 fingerprints to the Board.

Be aware that fingerprint processing may delay your application. Please make it a PRIORITY to complete the fingerprint process. Complete, sign and return the *Waiver Agreement and Statement* form directly to the Board.

☐ **Credit Card Payment Authorization Form** This form should be used by applicants for payment of the Kansas application fee by credit card. Please enter the required information and return the form directly to the Board at the address above.

ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

Select the discipline applying for and the license designation being requested.

☐ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

☐ 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 and Statement of Health:

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 _____
4. Do you presently have any physical or mental problems or disabilities which could affect 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.

ADDENDUM 2
KANSAS STATE BOARD OF HEALING ARTS

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. It is your continuing duty to update the Board on any changes once the application has been submitted.

1. ☐ 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 or educational program, including but not limited to medical school, prior to completing the training?

2. ☐ Yes ☐ No Have you ever had any application for any professional license refused or denied by any licensing authority?

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

4. ☐ 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?

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

6. ☐ 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?

7. ☐ Yes ☐ No Have you ever voluntarily surrendered any professional license?

8. ☐ 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?

9. ☐ Yes ☐ No Have you ever been notified or requested to appear before a licensing or disciplinary agency?

10. ☐ 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?

11 ☐ Yes ☐ No Has any professional association imposed any disciplinary action against you?

12. ☐ 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?

13. ☐ 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?

14. ☐ 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?

15. ☐ 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?

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

17. ☐ 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?

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

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

20. ☐ 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.

21 ☐ 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.

22. ☐ Yes ☐ No Have you ever been court-martialed or discharged dishonorably from the armed services?

23. ☐ 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?

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

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

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

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 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 drugs.

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: _____

Profession: Please select one: MD☐ DO☐

Street 1: _____

Street 2: _____

State/Zip: _____

Telephone: _____

Signature: _____

Date:

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

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 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 drugs.

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: _____

Profession: Please select one: MD ☐ DO ☐

Street 1: _____

Street 2: _____

State/Zip: _____

Telephone: _____

Signature: _____

Date: _____

ADDENDUM 4
KANSAS STATE BOARD OF HEALING ARTS

Applicant: Complete this form and email it to boardinquiry@fsmb.org. You must also check the box below.

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

Federation of State Medical Boards of the United States, Inc.
400 Fuller Wiser Road, Suite 300 | Euless, TX 76039
Tel (817) 868-4000 Fax (817) 868-4099

Physician Data Center Inquiry Form

Attention: State Board Inquiries

The Kansas State Board of Healing Arts is requesting a PDC Search concerning the following individual:

Last Name _____

First Name _____

Middle Name _____

Date of Birth _____

Daytime Phone _____

Email _____

Degree (MD, DO, or PA only) _____

Medical School _____

Year of Graduation _____

Last Four Digits of Social Security Number_____

ECFMG # (if applicable) _____

NPI Number _____

Please mail the result to the following address:

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612

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 FBI Privacy Act Statement.* Please complete, sign and date the *Waiver Agreement and FBI Privacy Act 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 http://www.ksbha.org/departments/licensing/licensingdept.shtml 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 or visit https://www.fbi.gov/file-repository/standard-fingerprint-form-fd-258-1.pdf/view to print a fingerprint card. If printing the card please print on card stock paper.

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 **$47**. A fingerprint card submitted without payment will not be processed.

Provide the law enforcement officer with a stamped envelope addressed to KSBHA 800 Jackson LL-Suite A., Topeka KS 66612 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 $47 as of February 1, 2015 to process. Resubmitted fingerprint cards will not be processed without payment.

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

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) 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 Authorized Recipient may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the above-referenced Authorized Recipient of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Authorized Recipient may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities until the criminal history background check is completed.

I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose to challenge the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. (See 5 United States Code (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C.534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).
Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies)

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

Routine Uses:
The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:
The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness.

Alternatively, you may obtain a copy of your **Kansas criminal history record information** (CHRI) to review for accuracy and completeness, by submitting a set of your fingerprints, a letter requesting your criminal history record, and payment of the appropriate fee to the KBI. For further details, including the current fee, visit the following Internet website: http://www.kansas.gov/kbi/info/info_brochures.shtml then find the brochure named "Record Checks for Non-Criminal Justice Purposes". Or, to provide official court documents to make a correction you may write to:

Kansas Bureau of Investigation
Attn: Criminal History Records
1620 SW Tyler
Topeka, Kansas 66612-1837

If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license, certification or registration, or adoption.

To obtain a copy of your **national CHRI, also known as the Identity History Summary**, for review and challenge you must submit a set of your fingerprints and the appropriate fee to the FBI. Information regarding this process may be obtained at: https://www.fbi.gov/services/cjis/identity-history-summary-checks. Or, you may write to:

FBI CJIS Division
Attn: Criminal History Analysis Team 1
1000 Custer Hollow Road
Clarksburg, West Virginia 26306

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34). The Authorized Recipient must submit a new set of fingerprints and fee to receive the updated federal criminal history record.

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:

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 5903.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information how to challenge my criminal records for accuracy and completeness.

Signature _____ Date _____

Printed Name _____ Date of Birth _____

Residential Address _____ City _____ State _____ Zip _____

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

Method of Verifying Identity: Driver's License ☐ State Issued ID Card ☐ Military ID Card ☐

State/Branch: _____ ID Number: _____

Agency Name: _____

Address: _____

Telephone: _____ Fax: _____

Name of Individual Verifying Identity: _____

AUTHORIZED RECIPIENT: 1. Must maintain original or arrange for KBI to maintain.
2. Must provide a copy to the applicant.

CREDIT CARD PAYMENT AUTHORIZATION

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

☐ DISCOVER NETWORK ☐ MasterCard ☐ AMERICAN EXPRESS ☐ VISA

CARD NUMBER

Verification Code

3-4 digit non-embossed number found on the card signature panel

Expiration Date

MO / YR

Name (as it appears on the credit card): _____

Billing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Telephone Number: _____ - _____ - _____

Payment Amount $ _____ Purpose of Payment: _____ (e.g. renewal, application)

Applicant/Licensee Name: _____

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

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

revised 1/28/11, kl

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at: http://www.fsmb.org/contact-a-state-medical-board/.

Please send this form to: Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Suite A
Topeka, KS 66612

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 Uniform Application for Physician State 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 Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

_____
Applicant's signature (must be signed in the presence of a notary)

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at https://www.fsmb.org/uniform-application/to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at https://www.fsmb.org/contact-a-state-medical-board/ to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to my license number _____ to the board at the address listed below.

Board name	Kansas State Board of Healing Arts
Mailing address	800 SW Jackson, Lower Level, Suite A
City/State/Zip	Topeka, KS 66612

Applicant signature _____ Date _____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____

Name of licensee (last, first, middle, suffix) _____

License type _____ License number _____ Issue date _____ Expiration date _____

1. Is this license current? If not current, please explain: ☐ Yes ☐ No

2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

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 _____ Date _____

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

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma awarded: _____

Name of school _____

**The social security number is to be used for purposes of identification only and may not be used or any other reason.*

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name	Kansas State Board of Healing Arts
Mailing address	800 SW Jackson, Lower Level, Suite A
City/State/Zip	Topeka, KS 66612

Applicant signature _____ Date _____

Section 2: Medical or Osteopathic School Verification

School name _____

Complete address w/country _____

School name if different when applicant attended _____

Hours of undergraduate education required for admission _____ Total weeks of education applicant attended _____

Attendance (mm/yyyy) from _____ to _____ Graduation date _____ Degree awarded _____

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? **If yes,** indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes ☐ No ☐

☐ Personal or family	From _____ to	☐ Approved	☐ Unapproved
☐ Academic remediation	From _____ to	☐ Approved	☐ Unapproved
☐ Health	From _____ to	☐ Approved	☐ Unapproved
☐ Financial	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a joint degree program	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a non-research special study (e.g., fellowship, intl. experience)	From _____ to _____	☐ Approved	☐ Unapproved
☐ Other _____	From _____ to _____	☐ Approved	☐ Unapproved

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? **If yes,** indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

☐ Academic	From _____ to	☐ Documentation attached
☐ Unprofessional conduct	From _____ to	☐ Documentation attached
☐ Behavioral reasons	From _____ to	☐ Documentation attached
☐ Other _____	From _____ to _____	☐ Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

5. Do the official records for this individual 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? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

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

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

Title _____ Date _____

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

Postgraduate Training Verification Form (Form #3)

Institution Name: ______________________________

Institution Address: ______________________________

____

Affiliated School: ______________________________

Applicant: Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

Program Director or designated Official: Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

Section 1:
To be completed by the Applicant.

Name: ______________________ **Suffix** _____ **Practitioner type: M.D.** ☐ **D.O.** ☐

Date of birth: ___________ **(mm/dd/yyyy) SSN*** ______________________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Name if different when diploma awarded: ______________________

Board Information: To be completed by the applicant.

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below:

Board Name: Kansas State Board of Healing Arts

Mailing address: 800 SW Jackson, Lower, Level, Suite A. Topeka, KS 66612

Applicant Please Sign Here →

Applicant Signature ______________________ **Date** __________

Section 2 :
Program Participation :

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected comple ion date in the "To" field.

Use one section per Department/Specialty. If he Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Report Internships, Residencies and Fellowships separately.

Training Level: _____ (e.g., 1, 2, 3, etc.)

☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: ______________________

From: __/__/____ **To:** __/__/____

Successfully Completed?: ☐Yes ☐No ☐In Progress

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

Training Level: _____ (e.g., 1, 2, 3, etc.)

☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: ______________________

From: __/__/____ **To:** __/__/____

Successfully Completed?: ☐Yes ☐No ☐In Progress

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

Training Level: _____ (e.g., 1, 2, 3, etc.)

☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: ______________________

From: __/__/____ **To:** __/__/____

Successfully Completed?: ☐Yes ☐No ☐In Progress

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

Unusual Circumstances:

Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper.
Attach pages as needed.

1. Did this individual ever take a leave of absence or break from his/her training? ---------------- ☐Yes ☐No
2. Was this individual ever placed on probation? ---------------- ☐Yes ☐No
3. Was this individual ever disciplined or placed under investigation? ---------------- ☐Yes ☐No
4. Were any negative reports for behavioral reasons ever filed by instructors? ---------------- ☐Yes ☐No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ---------------- ☐Yes ☐No

Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

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. This section MUST be signed by the program director (M.D. or D.O. only). **(Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)**

Signature: ______________________

Print name: ______________________

Title: ______________________

Email address: ______________________

Phone Number: ______________________ **Date:** __________

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Fifth Pathway Verification Form (Form #4)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

Program Director or Designated Official: Complete Section 2 of this form. Mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma was awarded: _____

Name of medical school _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

Board name	Kansas State Board of Healing Arts
Mailing address	800 SW Jackson, Lower Level, Suite A
City/State/Zip	Topeka, KS 66612

Applicant signature _____ Date _____

Section 2: Fifth Pathway Verification

Institution name _____ Affiliated school _____

Institution name if different when applicant attended _____

Institution address w/country _____

Type of Clinical Rotation	From	To	Weeks Credit

Completed?

☐ Yes. Attendance was from _____ to _____. Completion date was _____.

☐ No. Withdrawal* date was _____. **If the applicant withdrew or was dismissed, please explain below.*

☐ No. Dismissal* date was _____. **If the applicant withdrew or was dismissed, please explain below*

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 _____ Date _____

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

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.