



**STATE BOARD OF HEALING ARTS**

800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612

(785) 296-7413 / e-mail: [KSBHA\\_DataRequests@ks.gov](mailto:KSBHA_DataRequests@ks.gov) / Fax: (785) 368-7102 / <https://ksbha.ks.gov>

**QUERY ORDER FORM**

**Organization:**

**Telephone:**

**Fax:**

**Name:**

**Email Address:**

**Street Address:**

**City:**

**State:**

**Zip:**

The requested data will be provided in an Excel spreadsheet and sent via email.

Fee: \$45 (please submit the required payment with this form)

**QUERY OPTIONS (please check all boxes you are requesting for your report)**

**License Types:**

- (AT) Athletic Trainer
- (DC) Chiropractic Doctor
- (DO) Osteopathic Doctor
- (DPM) Podiatric Doctor
- (LRT) Radiologic Technologist
- (MD) Medical Doctor
- (ND) Naturopathic Doctor
- Naturopathic Acupuncturist
- (OT) Occupational Therapist
- (OTA) Occupational Therapy Assistant
- (PA) Physician Assistant
- (PT) Physical Therapist
- (PTA) Physical Therapist Assistant

- (RT) Respiratory Therapist
- (LAC) Licensed Acupuncturist
- (CMN-I) Independent Certified Nurse Midwife
- (TW) Telemedicine Waiver
- Contact Lens Distributor

**MD/DO Specific:**

- Institutional
- Postgraduate Permit
- Special Permit
- Resident Active

**License Status:**

- Active
- Exempt
- Inactive
- Federal Active
- Reentry Active

**Sort Order:**

- Alphabetical
- County
- License Type
- Zip Code
- Other

**Requested Fields:** *The release of a complete mailing address is subject to approval by our General Counsel. Data provided may be limited or redacted.*

- |  |  |  |  |
|--|--|--|--|
| <b>Mailing:</b>                        | <b>Business:</b>                       | <input type="checkbox"/> Year of Birth           | <input type="checkbox"/> Disciplinary Action (Y/N) |
| <input type="checkbox"/> Address       | <input type="checkbox"/> Address       | <input type="checkbox"/> License Number          | <input type="checkbox"/> License Type              |
| <input type="checkbox"/> County        | <input type="checkbox"/> County        | <input type="checkbox"/> Degree Date             | <input type="checkbox"/> License Status            |
| <input type="checkbox"/> Phone Number  | <input type="checkbox"/> Phone Number  | <input type="checkbox"/> Original License Date   | <input type="checkbox"/> Specialization            |
| <input type="checkbox"/> Email Address | <input type="checkbox"/> Email Address | <input type="checkbox"/> License Expiration Date | Please List:                                       |

**To order:** submit this form by e-mail or fax.

**YOU MUST CERTIFY:**

( ) Neither I nor any person within our organization intends to, and will not: (A) Use any list of names or addresses contained in or derived from the records or information for the purpose of selling or offering for sale any property or service to any person listed or to any person who resides at any address listed; and will not (B) sell, give or otherwise make available to any person any list of names or addresses contained in or derived from the records or information for the purpose of allowing that person to sell or offer for sale any property or service to any person listed or to any person who resides at any address listed.

Signature

Date: mm/dd/yyyy

Printed name of person signing



## CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Submit the completed form to the Board. Payments are processed in order of date received.

### CREDIT CARD INFORMATION:

<b>Card Type:</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<b>Card Number:</b> _____			
<b>Expiration Date:</b> (MM/YY) _____		<b>Verification Code:</b> _____	
<b>Purpose of Payment:</b> _____ <small>(Application, NPDB, KBI, Verification of License Fee, etc.) To view license Fee List, <a href="#">click here.</a></small>			<b>Amount:</b> _____
<b>Name of Cardholder:</b> _____			
<b>Mailing Address</b>	Street Address: _____		
	City: _____	State: _____	Zip: _____
	Phone: _____	Email: _____	

### APPLICANT/LICENSEE INFORMATION:

<b>Name of Applicant/Licensee:</b> _____	<b>License Number:</b> _____
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By signing below, I certify and give permission to the Kansas State Board of Healing Arts to charge the above-mentioned amount. I understand that failure to submit the required information will delay processing of the payment.

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please note: The information on this form is considered personal and not subject to disclosure under the Kansas Open Records Act.