LIMITED PERMIT INITIAL APPLICATION

The Limited Permit is available to practice the appropriate branch of the healing arts only as a charitable health care provider as defined in K.S.A. 75-6102. *See* K.S.A. 65-28,125. **Those who hold a Limited Permit in Kansas shall be subject to all the rules and regulations pertaining to the practice of the healing arts.** Completed application and forms can be emailed to KSBHA_Licensing@ks.gov or mailed to the KSBHA. If a seal or notary is required, it must be clearly visible to be accepted by email. **The application will not be accepted handwritten.**

FEES
Application $30
NPDB $3
ALL FEES ARE NON-REFUNDABLE

REQUIREMENTS

- Received a degree from a healing arts school
- Current full, active, and unrestricted license in another state to practice your profession
- Has not been previously licensed in Kansas
- Complete application with all questions answered
- Notarized and signed Affidavit and Authorization
- ECFMG Certification Status Report
- Official transcript with final medical degree awarded sent directly from the school or approved third party
- Documentation for any "yes" answers to the Attestation Questions
- Documentation of name change, if applicable

IDENTIFYING INFORMATION

Provide your full legal name. If the name on the application differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name.

First Name:	Middle Name:	Last Name:	Suffix:
List all other names used, including maiden name:			
Social Security Number:	Date of Birth: (MM/DD/YYYY)		
Place of Birth:		Male ☐	Female ☐

ADDRESSES

Addresses cannot be a Post Office Box, except qualified participants under the Safe at Home Act, K.S.A. 75-451 *et seq*. Your home address will not be available to the public. The business address is public and will be posted on the Board's website. The Board will contact you at the preferred address.

Home Address	Street Address:			
	City:		State:	Zip:
	Phone:	Email:		
Business Address	Street Address:			
	City:		State:	Zip:
	Phone:	Email:		
Preferred Address: (mailed and emailed correspondence will be sent to the selected address)			Home ☐	Business ☐

LEGAL AUTHORITY TO WORK IN THE U.S.

Are you a US Citizen? ☐ Yes ☐ No If you answered NO, are you (check one):	
☐	A qualified alien (as defined in 8 U.S.C.A § 1641.
☐	A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A § 1101 *et seq*).
☐	An alien who is paroled into the United States under 8 U.S.C.A § 1182(d)(5) for less than one year.
☐	A foreign national, not physically present in the Unites States.
	Other:

NATIONAL PROVIDER IDENTIFIER (NPI)

The NPI is a unique 10-digit numeric identifier for health care professionals available from the Centers for Medicare and Medicaid Services ("CMS"). Provide your NPI number or if you do not have an NPI number check the corresponding box.

I do not have an NPI Number ☐	NPI number:

ECFMG CERTIFICATION

For IMGs, provide your ECFMG certification number and date issued. Request a Certification Status Report be sent directly to the Board. If you are not an IMG check the corresponding box.

I do not have an ECFMG Number ☐	Certificate Number:	Issue Date:

MEDICAL EDUCATION

List all medical schools you have attended, **even those from which you did not graduate**. Attach additional page if necessary. Request an official transcript with the final medical degree awarded be sent from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors.

Name of Medical School:			
City:	State:	Start Date:	End Date:
Degree Awarded:		Date Awarded:	

Name of Medical School:			
City:	State:	Start Date:	End Date:
Degree Awarded:		Date Awarded:	

EMPLOYMENT/PROFESSIONAL HISTORY

In chronological order, list all healthcare employment/professional history during the past 2 years. Attach additional page if necessary. Include the actual work address, not corporate headquarters.

I have not worked in a healthcare position during the past 2 years ☐

Employer	Job Description/Title	Address	Start Date	End Date

OTHER LICENSES/PERMITS/CERTIFICATIONS

List all states or jurisdictions in which you currently, or have ever held, a **healthcare related license, permit or certification, permanent or temporary.** Attach additional page if necessary.

State	Issue Date	License Type	License Number

PRACTICE LIMITATIONS

K.S.A. 65-28,125 authorizes Limited Permit holders to practice the appropriate branch of the healing arts only as a charitable health care provider but shall not authorize the person receiving the permit to otherwise engage in the practice of the healing arts in this state.

I certify that I understand and agree to comply with the Limited Permit practice limitations and will provide professional services in this state only as a charitable health care provider as defined in K.S.A. 75-6102.	☐

ATTESTATION QUESTIONS

Please answer each of the following questions. **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 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 question, check the "yes" box and submit the appropriate documentation. 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. Please be advised that a false response to any of these questions may be grounds for denial of licensure. If a question is not applicable, then check the "no" box.

Full Name of Applicant _____ Date _____

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 program, excluding academic probation in medical school, prior to completing the training? Yes ☐ No ☐
2. Have you ever had any application for any professional license, registration, or certificate denied by any licensing authority? Yes ☐ No ☐
3. Have you ever been denied the privilege of taking an examination required for any professional license, registration, or certificate? Yes ☐ No ☐
4. While working in a healthcare facility as a staff member (including postgraduate training) did you ever have your privileges censured, limited, suspended, revoked, or received other disciplinary action? Yes ☐ No ☐
5. While working in a healthcare facility as a staff member (including postgraduate training) did you ever voluntarily or involuntarily resign while under investigation? Yes ☐ No ☐
6. Have you ever been denied privileges with any health care facility? Yes ☐ No ☐
7. 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 ☐
8. Have you ever voluntarily surrendered any professional license registration, or certificate, in lieu of formal disciplinary proceedings? Yes ☐ No ☐
9. Has any licensing authority ever limited, suspended, revoked, censured or placed you on probation, or have you had any other disciplinary action taken against any professional license, registration, or certificate you have held? Yes ☐ No ☐
10. Have you ever been requested to appear before a licensing authority? Yes ☐ No ☐

11. To your knowledge, have any complaints or charges ever been filed against you, or are you currently under investigation, with any licensing agency, professional association, or health care facility? Yes ☐ No ☐

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

13. Do you currently have any physical or mental health condition (including alcohol or substance use) that impairs your ability to practice your profession in a competent, ethical, and professional manner? Yes ☐ No ☐

14. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate? Yes ☐ No ☐

15. Have you ever had your Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration revoked, suspended, or restricted in any way, or surrendered in lieu of formal proceedings? Yes ☐ No ☐

16. Have you ever been arrested? You must include all arrests including those that have been set aside, dismissed, expunged, pardoned, or where a stay of execution has been issued. Yes ☐ No ☐

17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation? You must include those that have been set aside, dismissed, pardoned, or expunged, or where a stay of execution has been issued. Yes ☐ No ☐

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

19. 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 ☐

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

21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any state or federal Medicaid or Medicare Programs, or private insurance company? Yes ☐ No ☐

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

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant: In the presence of a notary public, sign and date this form with attached photo. Email completed form to KSBHA_Licensing@ks.gov or mail directly to the Kansas State Board of Healing Arts.

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 the Limited Permit of 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 a change occurs any time prior to a Limited Permit to practice my profession 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 Limited Permit to practice my profession.

Applicant Photograph

Attach a 2 x 3- inch color photograph of applicant, with head and shoulder areas only, taken within the last 90 days.

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

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

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

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 _____

LICENSE VERIFICATION FORM

Send to all states or jurisdictions in which you currently, or have ever, held a license, permit, or certification, permanent or temporary. 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 email to KSBHA_Licensing@ks.gov or mail it 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; 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: _____

Signature: _____ (SEAL)

Title: _____

State Board of: _____

Date: _____

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

THIRD PARTY RELEASE

If you would like the Kansas State Board of Healing Arts ("Board") staff to talk with third parties about your application complete this form. This form provides authorization for the Board to release information regarding your application to third parties. This information includes, but is not limited to: application information, license verification, status change, address changes, Kansas Health Care Stabilization Fund information, continuing education information, audit information, and past or current legal issues and documents. This authorization expires one year from the date of signature. You can revoke this authorization at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to receipt of your written request. A reproduction of this authorization shall have the same effect as the original. Email to KSBHA_Licensing@ks.gov or mail it directly to the Board.

I, _____, authorize Board staff to release and discuss any and all information pertaining to my application, with the following individuals:

1. Name: _____
   Phone: _____
   Email: _____
   Relationship: _____

2. Name: _____
   Phone: _____
   Email: _____
   Relationship: _____

I acknowledge by my signature, that although I am not required to authorize the Board to release information to third parties, I am giving my consent for Board staff to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information which has already been released with consent, prior to my revocation.

_____ _____

Signature of Applicant Date

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

Email the completed form to KSBHA_Licensing@ks.gov or mail directly to the Board. Payments are processed in order of date received.

Name of Applicant/Licensee:		License Number:	
Purpose of Payment:		Amount:	

(Application, NPDB Fee, KBI Fee, Verification of Licensure, etc.)

Name of Cardholder:			
Billing Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	

Card Type: ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS ☐ MasterCard	
Card Number:	
Expiration Date: (MM/YY)	Verification Code:

**Do not add spaces or dashes to numbers*

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.

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