APPLICATION FOR SPECIAL PERMIT
PRACTICE UNDER SPONSORING PHYSICIAN

A special permit is only available to graduates of the University of Kansas School of Medicine who have not yet engaged in a postgraduate training program. The permit allows limited practice in an underserved area under the supervision of a sponsoring physician. For a complete description, see KSA 65-2811a. Completion of this application form is necessary for consideration for a special permit. Disclosure of this information is voluntary; however, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for a permit or permit renewal have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application may be subject to the public information laws of this state.

Please type or print. When space provided is insufficient, attach additional pages. You may reproduce these blank forms as needed. Please make sufficient copies of all forms before you begin.

1. Indicate your full legal name. If your name is different from that shown on your documentation you must submit a copy of the legal document of name change.

Full Name: _____ (first) _____ (middle) _____ (last) _____ (suffix)

Other names used, including maiden name: _____

2. Include residence, mailing and e-mail address. Residence address may ***not*** be a Post Office Box, except qualified participants under the Safe At Home Act, K.S.A. 75-451 *et seq.* may use substitute residential and mailing addresses.

Residence Address: _____ (street) _____ (city) _____ (county) _____ (state) _____ (zip)

Mailing Address: _____ (public information) (street) (city) (county) (state) (zip)

E-mail: _____

3. Daytime phone number (include area code): _____

4. Identification. Disclosure of your social security number is required by federal mandates set forth in 42 U.S.C.S. § 666(a)(13). K.S.A. 74-148(a) provides that every application by an individual for a professional license shall require the applicant's social security number. K.S.A. 74-139 requires disclosure of your social security number upon request to the Kansas director of taxation. Your social security number may be provided for child support enforcement actions, to the Kansas director of taxation, for reporting disciplinary actions to the National Practitioner Data Bank-Health Integrity and Protection Data Bank (NPDB-HIPDB) as required by 45 C.F.R. §§ 61.1 *et seq.* Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Such disclosure is for identification purposes only. Your social security number will not be released for any other purpose not permitted by law.

Date of Birth: _____ Place of Birth: _____ (city) (state/jurisdiction) (country) Sex: M ☐ F ☐

Social Security/Tax ID. No: _____ NPI (National Provider Identifier): _____ NPI Not Applicable: ☐

Are you a U.S. Citizen? Y ☐ N ☐ 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 United States. ☐

Other: _____

5. I am a graduate of the University of Kansas School of Medicine. **Enclose or send an official and final transcript showing the degree awarded or official sealed letter of completion from your program.**

Location (Please check one): ☐ Kansas City, Kansas ☐ Wichita, Kansas

6. Postgraduate Training Programs:

Did you apply to a postgraduate training program: Yes ☐ No ☐

Did you match? Yes ☐ No ☐

7. Recommendation by a Kansas licensed physician that has known the applicant for a minimum of 1 year.

I _____ , a licensed and practicing physician in the state of Kansas
name

affirms that _____ has been known to me for _____ year(s), and that applicant, to
name of applicant

the best of my knowledge, is an ethical practitioner, is of good professional character, and not addicted to the use of alcohol or drugs.

_____ signature

_____ address

_____ date

_____ city, state and zip

8. Photo.

Attach a **2"x 3" 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.

Photo here

Applicant Name: _____
please type or print

9. List all employment/professional activities since you have completed medical school. Account for <u>all</u> time and explain all gaps. Attach an additional sheet if necessary.

☐ None.

Type of Activity:	Dates: from mm/yy	to mm/yy	Location:
Type of Activity:	Dates: from mm/yy	to mm/yy	Location:
Type of Activity:	Dates: from mm/yy	to mm/yy	Location:

10. 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 special permit to practice 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 here

_____ Notary Public

_____ Commission Expires

11. Sponsoring Physician Information:

Sponsoring Physician's name: _____

Sponsoring Physician's license number: _____

Practice Address(es) at which the special permit holder will work:

_____
street city county state zip

I, _____ am a person licensed to practice medicine and surgery and practice in an area of
sponsoring physician's name
Kansas which is determined under K.S.A. 76-375 to be medically underserved. I have agreed to sponsor, supervise and accept responsibility for the services rendered by _____ as a Special Permit Holder. I agree to
applicant's name
be physically present within the healthcare facility or other site of patient care and be immediately available to the Special Permit Holder at all times the Special Permit Holder is practicing. I agree to comply with the requirements of K.S.A. 65-28-127 in my supervision of the Special Permit Holder.

_____ _____
Signature of Sponsoring Physician date

Applicant Name: _____
please type or print

Third Party Authorization

Must be signed by applicant and notarized.

I,_____ , hereby authorize all hospitals, institutions or organization, 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

SEAL here

_____ Commission Expires

Revised 4-13-11 kl

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

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.

Kansas
State Board of Healing Arts

FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS

A criminal background check is required prior to issuance of licensure. Be aware that fingerprint processing may delay your application. **Please make it a priority to complete the fingerprint process.**

Following is the Waiver Agreement and FBI Privacy Act Statement. Please complete, sign and date the top portion of this form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Please visit https://www.nbinformation.com/locations/locationMap.php for a listing of fingerprinting locations.

Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the fingerprints must be printed on the fingerprint card and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email KSBHA_Licensing@ks.gov or call (785) 296-7413.

Complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submission. Include name, aliases, 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.

Mail the completed Waiver Agreement and fingerprint card to the Board. You may want to use a mailing service that allows for delivery confirmation.

Kansas State Board of Healing Arts
Attn: Licensing
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612
Phone: (785) 296-0934
Email: KSBHA_Licensing@ks.gov

Fingerprint results are valid for 6 months from the date received. Applications for licensure completed after the 6-month period will be required to submit a new Waiver Agreement, fingerprint card, and $57 fee.

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) 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. The fingerprints are authorized to be submitted under the authority of the National Child Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law (Pub. L.) 103-209 and Pub. L. 105-251. Pursuant to K.S.A. 22-4701 et seq., K.S.A. 22-5001, K.S.A 75-712i, and 2022 Kansas Laws Ch. 92, § 1 (Senate Sub. for H.B. 2495), 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 of challenging 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 (U.S.C.) 552a(b); 28 U.S.C. 534(b);34 U.S.C. 40316, Article IV(c); 28 CFR 20.21(c), 20.33(d), 906.2(d); and 2022Kansas Laws Ch. 92, § 1 (Senate Sub. for H.B. 2495).

I understand that my fingerprints will be retained by the KBI and/or the Federal Bureau of Investigation if the Authorized Recipient participates in the state or national Rap Back program for continued suitability for being an employee, volunteer or contractor, or eligibility for any license, certification, registration, or adoption. The Rap Back program will notify the Authorized Recipient when there are updates to my criminal history record. Once I am no longer employed, a volunteer contractor, licensed, certified, registered, or seeking adoption, the Authorized Recipient shall request my fingerprints be removed from the state and/or national Rap Back program.

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of identification records and 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 U.S.C. 552a), the Authorized Recipient 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 requires 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).

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 U.S.C. 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 at no cost.

To Challenge Your Kansas Criminal History Record Information (CHRI)
You may also obtain a copy of your Kansas 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. 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.

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".

To Challenge Your National Criminal History Record Information (CHRI)
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. 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).

Information regarding this process may be obtained at: https://www.fbi.gov/services/cjis/identity-history-summary-checks.

DO NOT SEND THIS FORM TO THE FBI

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

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 K.S.A. 21-5903.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information about 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 ☐ Passport

State/Branch: _____ ID Number: _____

Agency Name: _____

Address:_____

Telephone: _____ Fax: _____

Name of Individual Verifying Identity:_____

APPLICANT: ***Please return all pages to the Authorized Recipient***

_____

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

DO NOT SEND THIS FORM TO THE FBI

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

GENERAL INFORMATION AND INSTRUCTIONS
Special Permit
Please visit www.ksbha.org for all information governing a Special Permits.

Thank you for your interest in obtaining a Special Permit in Kansas. 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.

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 by the Kansas State Board of Healing Arts (KSBHA).

One of the missions of KSBHA is public protection through effective licensure and enforcement. One way the public is safeguarded is by issuing licenses to fully qualified, competent and ethical applicants. You will be asked a series of attestation questions. A "yes" answer is not an automatic disqualification from licensure. All applicants are considered on an individual basis. You may be requested to submit additional information or documents to the requirements mentioned herein before the application will be deemed complete to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. Failure to fully disclose could constitute grounds alone for denial of your application. Please avoid some of the common excuses: "My attorney told me I don't have to disclose." or "I did not think the prior act had anything to do with my profession or that it was still on my record or that it happened so long ago." There is no excuse for not disclosing.

Application fees must be submitted with the application. These *fees are* ***non-refundable*** and will be processed upon receipt. The Kansas Special Permit application fee is **$30.** Also, a background check fee of **$57** and a National Practitioner Data Bank ("NPDB") report fee of **$3** must accompany the application. This totals **$90**. Board staff directly runs an NPDB report for all applicants. Please do not submit an NPDB self-query. To pay by debit or credit card, complete the Credit Card/Debit Card Authorization Form. Please make all checks payable to the KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card.

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.

Special Permit applicants are 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?

ALL questions answered on the application
Request official/final transcript or completion letter submitted & sealed by the medical school
Signature of recommendation #7
Head and shoulder photograph (size: **2X3** taken within 90 days of application)#8
Application Fee
Criminal Background report fee
Completed fingerprint card or Livescan print out and have mailed to the Board
Notarize and sign Oath #10
Signature of sponsoring physician #11
Documentation to any "yes" answers to #12
Notarize and sign Release Form
NPDB fee
Signed Waiver Agreement and Statement

revised 7/1/24 kl

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

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

CREDIT CARD INFORMATION:

Card Type: ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS ☐ MasterCard			
Card Number: _____			
Expiration Date: (MM/YY) _____	**Verification Code:** _____		
Purpose of Payment: _____ *(Application, NPDB, KBI, Verification of License Fee, etc.) To view license Fee List, click here.*		**Amount:** _____	
Name of Cardholder: _____			
Mailing Address	Street Address: _____		
	City: _____	State: _____	Zip: _____
	Phone: _____	Email: _____	

APPLICANT/LICENSEE INFORMATION:

Name of Applicant/Licensee: _____	**License Number:** _____

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.

Kansas State Board of Healing Arts
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