GENERAL INFORMATION OCCUPATIONAL THERAPIST (OT) AND OCCUPATIONAL THERAPY ASSISTANT (OTA)

Thank you for your interest in reinstating your Kansas license. Please read the following information carefully. This information is vital to the successful completion of your application and often, questions you may have, are covered. For all information governing the practice of Occupational Therapy in Kansas, please visit the Statute and Regulation Handbook.

The application and all forms are fillable PDFs and can be submitted electronically by emailing KSBHA_Licensing@ks.gov. If a seal or notary is required, it must be clearly visible to be accepted by email. **Pages 1-3 of the application will not be accepted handwritten.** KSBHA highly recommends that you make and keep copies of all the items you submit to the Board. As a reminder, **please do not make a commitment to work dates, prior to being licensed**.

Applications are processed in order of date received. Please allow **at least 2 to 4 weeks** for the processing of your application. After an application is processed if something is identified as missing, a missing requirement letter ("MRL") is sent to the preferred email address. Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application. For updates, login to the online portal. When the license is reinstated a notification with the wallet card is sent to the preferred email address.

If your license is reinstated before January 1, you will be required to renew during that year's renewal period. If your license is reinstated after January 1, you will not be required to renew until the following calendar year. Renewal starts February 15; late renewal starts April 1. All OT/OTA licenses cancel May 1, if not renewed.

Fees:
Application**: $80**
NPDB: **$3**
ALL FEES ARE NON-REFUNDABLE

If you:	**Then complete the:**
Never held a Kansas Occupational Therapy license	Initial Application
Previously held a Kansas Occupational Therapy license that is now cancelled	Reinstatement Application

OT/OTA Application Check List:

☐	Complete application with all questions answered.
☐	Request verification of other licenses, permits or certifications, if applicable.
☐	Provide proof of professional liability insurance.
☐	Provide proof of continuing education, if applicable.
☐	Provide documentation for any "YES" answers to the Attestation Questions.
☐	Provide documentation of name change, if applicable.
☐	Notarize and sign the Affidavit and Authorization.
☐	Complete Expedited Licensure Questionnaire
☐	Complete and sign the Third-Party Release, if applicable.

APPLICATION INSTRUCTIONS – OCCUPATIONAL THERAPIST (OT) AND OCCUPATIONAL THERAPY ASSISTANT (OTA)

Application Fees: Application fees must be submitted with the application. These *fees are* ***non-refundable*** and will be processed upon receipt. The Kansas OT/OTA application fee is **$80**. Also, a National Practitioner Data Bank ("NPDB") report fee of **$3** must accompany the application. This totals **$83**. 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 KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card.

Name: 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. Documentation is not required if it has been previously submitted.

Identification: Federal Law, at 42 U.S.C.S. § 666(a)(13), mandates that this agency record social security number on your application. K.S.A. 74-148(a) provides that every application by an individual for a professional license shall request the applicant's social security number. K.S.A. 74-139 requires this agency to disclose 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, or 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 by this agency of your social security number is voluntary to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your social security number will not be released for any other purpose not permitted by law.

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 mailing and email address. If your address or contact information changes, you must notify the Board within 30 days by completing the Change of Address Form or in the Online Portal.

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. Provide your NPI number or if you do not have an NPI number check the corresponding box.

Employment/Professional History: In chronological order, list all healthcare employment/professional history since the cancellation of your Kansas license. Account for all months and explain all gaps. Attach additional page if necessary. Include the actual work address, not corporate headquarters.

Other Licenses/Permits/Certifications: List all state or jurisdictions in which you currently, or have ever held, a healthcare related license, permit, or certification, permanent or temporary. The Board will verify your credentials for any state or jurisdiction that provides free and current verifications on their official state website and includes the following information: issue date, expiration date, and any pending or past disciplinary action. If the Board is unable to verify your credentials, you may complete the Verification Form and forward to all licensing agencies. Please check with the licensing agency to see if a fee is required for this information prior to sending the form. The Board accepts electronic verifications directly from the licensing agency or their official third-party vendor. Send electronic verifications to KSBHA_Licensing@ks.gov. If you have never held a healthcare related license, permit, or certification in another state or jurisdiction check the corresponding box.

Professional Liability Insurance: K.A.R. 100-54-13 requires OTs licensed in Kansas to maintain professional liability insurance. Individual coverage of not less than $100,000 per claim, and not less than $300,000 for all claims made during the period of coverage; or coverage through the individual's employer under an additional insured policy of not less than $1,000,000 per claim, and not less than $3,000,000 for all claims made during the period of coverage.

Submit one of the following as proof of coverage (proof must include the insurance company's information, applicants name, coverage amounts, and coverage dates):

- Certificate of Insurance
- Letter of intent from the liability insurance company or employer

When the license is ready for approval:

- If the professional liability insurance is effective upon licensure approval or has a past effective date the license will be issued that day.
- If the professional liability insurance has a future effective date the license will be approved but will not be issued or become effective until the date the professional liability insurance goes into effect. Furthermore, the license effective date cannot be more than 90 days from the date the license is ready for approval. If at the time the license is ready for approval the professional liability insurance effective date is more than 90 days out, the license will not be approved, and you will be contacted to provide a policy with an updated effective date.

Continuing Education: Proof of continuing education may be required. Please see K.A.R. 100-54-8 in the Occupational Therapy Handbook and submit proof if applicable.

Attestation Questions: The mission of the Board is to protect the public which it does so in part, through effective licensure and enforcement. The public is safeguarded by issuing licenses to qualified, competent, and ethical applicants. In the application, you will be asked a series of attestation questions. A "yes" answer to an attestation question is not an automatic disqualification for licensure – each applicant is considered on an individual basis. **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. You may be requested to submit additional information or documents. It is your continued duty to update the Board on any changes once the application has been submitted. Please keep in mind, **failure to fully disclose may constitute grounds for denial of your application**.

Affidavit and Authorization for Release of Information: In the presence of a notary public, sign, and date this form. Photo must be 2 x 3-inchs, in color, of the head and shoulder area only, and taken within the last 90 days. Black and white photographs, proof photographs, negatives, photographs cut from books or newspaper articles, or poor-quality photographs are **NOT** accepted.

Expedited Licensure Questionnaire: To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406, complete the questionnaire and submit with your application.

Third Party Release: Complete this form if you would like Board staff to talk with third parties about your application.

How to Check the Status of Your Application: Once your application is received and processed, you will be notified via email of any missing items and how to check the status of your application online.

OCCUPATIONAL THERAPIST (OT) AND OCCUPATIONAL THERAPY ASSISTANT (OTA) REINSTATEMENT APPLICATION

Completed application and forms can be emailed to KSBHA_Licensing@ks.gov or mailed to the Kansas State Board of Healing Arts. If a seal or notary is required, it must be clearly visible to be accepted by email. **Pages 1-3 of the application will not be accepted handwritten.** As a reminder, **please do not make a commitment to work dates, prior to being licensed.**

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. Documentation is not required if it has been previously submitted.

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. You may consider listing the postgraduate program as the business address. 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:

U.S. ARMED FORCES SERVICE

U.S. Armed Forces Service: ☐ Yes ☐ No	Branch:	
Start Date:	End Date:	Type of Discharge:

EMPLOYMENT/PROFESSIONAL HISTORY

In chronological order, list all healthcare employment/professional history since the cancellation of your Kansas license. Account for all months and explain all gaps. Attach additional page if necessary. Include the actual work address, not corporate headquarters.

Employer	Job Description/Title	Address	Start Date	End Date

OTHER LICENSES/PERMITS/CERTIFICATIONS

List all state or jurisdictions in which you currently, or have ever held, a **healthcare related license, permit or certification, permanent or temporary.** If you have never held a healthcare related license, permit or certification in another state or jurisdiction check the corresponding box. The Board will attempt to verify your credentials. If the Board is unable to verify your credentials you will be notified.

I have never held a healthcare related license, permit or certification in another state or jurisdiction ☐			
State	Issue Date	License Type	License Number

PROFESSIONAL LIABILITY INSURANCE (OTs Only)

K.A.R. 100-54-13 requires OTs licensed in Kansas to maintain professional liability insurance. Individual coverage of not less than $100,000 per claim, and not less than $300,000 for all claims made during the period of coverage; or coverage through the individual's employer under an additional insured policy of not less than $1,000,000 per claim, and not less than $3,000,000 for all claims made during the period of coverage.

Submit one of the following as proof of coverage (proof must include the insurance company's information, applicants name, coverage amounts, and coverage dates):

- Certificate of Insurance
- Letter of intent from the liability insurance company or employer

I certify that I have read and understand the professional liability insurance requirements and will maintain compliance while holding an active license in Kansas.	☐

CONTINUING EDUCATION

Proof of continuing education may be required. Please see K.A.R. 100-54-8 in the Occupational Therapy Handbook and submit proof if applicable.

EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406[i], please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military/law enforcement agencies.

1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes ☐ No ☐ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes☐ No☐ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

3. Do you currently reside in Kansas? Yes☐ No☐ If yes:

   Current Kansas Residence Address:_____

4. If you do not currently reside in Kansas, do you intend* to establish residency in Kansas within the next 6 months? ***If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military agencies in other jurisdictions.*** Yes ☐ No ☐ If yes:

   Intended Kansas Residence Address:_____

   Expected Date of Commencing Residence:_____

If you answered "no" to all questions #1 through #4, you do not need to answer questions #5 through #7.

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. ***This does not include certifications or registrations issued by private boards, professional societies, or any organization other than a government body of a state, district, or territory of the U.S.*** Yes☐ No☐ If no:

   a. Have you practiced the profession for which you are seeking licensure in Kansas for at least 3 years in a state that does not license/register/certify the profession? Yes ☐ No☐

   b. Have you practiced the profession for which you are seeking licensure in Kansas for at least 2 years in a state that does not license/register/certify the profession and you held a certification or registration issued by a private organization during those 2 years? Yes☐ No☐ If yes:

      Organization that issued private certification/registration: _____ Date Issued: _____

*** "Active practice" does not include care provided while in a training program, residency, or fellowship; or employment that consisted solely of research activities or administrative duties. The Board generally considers active practice to be direct patient care that for either (1) at least one full day per week for 50 weeks during a year; or (2) 400 hours during a year.**

6. Have you actively practiced* the profession for which you are seeking licensure in Kansas during the last 2 years? Yes☐ No☐

If you answered "yes" to question #6, you do not need to answer question #7.

7. If you answered "No" to questions #6, please provide a detailed explanation regarding your active clinical practice and direct patient care during the 12 months immediately preceding the submission of your application. Please explain any gaps in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

[i] An applicant who has not been in the active practice of their occupation during the two years preceding the application for which a license is sought, may be required to complete additional testing, training, monitoring or continuing education as the KSBHA deems necessary to establish present ability to practice in a manner that protects the health and safety of the public K.S.A. 48-3406(d).

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 to KSBHA_Licensing@ks.gov or mail it 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 Occupational Therapist or Occupational Therapy Assistant 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 Occupational Therapy 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 Occupational Therapy.

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 last name, first name, middle initial, 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 _____

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

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
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax (785) 368-7102; Email: KSBHA_HealingArts@ks.gov
www.ksbha.org