REINSTATEMENT APPLICATION FOR PHYSICIAN ASSISTANT

Completion of this application form is necessary for consideration for licensure. 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 licensure or 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. Kansas License no:_____

2. 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 the name change. If your name is different on your Kansas license you will need to complete the *Name Change* form. You can download the form from our website or call to have mailed.

Full Name: _____
first middle last suffix

Other names used, including maiden name:_____

3. 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: _____

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

5. 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.

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: _____

6. List all professional activities since the time of cancellation of your Kansas license. Attach an additional sheet if necessary. Include actual work address, not corporate headquarter's address.

Activity:_____ Employer (if applicable) _____

Location:_____ Dates: From _____ To _____
city state mm/yy mm/yy

Activity:_____ Employer (if applicable) _____

Location:_____ Dates: From _____ To _____
city state mm/yy mm/yy

Activity:_____ Employer (if applicable) _____

Location:_____ Dates: From _____ To _____
city state mm/yy mm/yy

Activity:_____ Employer (if applicable) _____

Location:_____ Dates: From _____ To _____
city state mm/yy mm/yy

7. List all states or jurisdictions in which you are currently or have ever been licensed, registered or certified as a physician assistant. Attach an additional sheet if necessary. KSBHA will verify your credentials except for any state that does not provide free and current verifications on their official state website. For those states, you may complete the attached *Licensure Verification* form and forward to all Boards or similar entities in which you have held a PA license, registration or certification. Some entities charge a fee for this information. Contact the entity to determine their requirements.

State/Jurisdiction	License, Registrant, Certificate no.	Status	Issue Date

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

9. License Designation. Please select the license designation you are requesting.

Active ☐ A license issued to a person authorizing practice as a physician assistant. Applicants for active licensure must provide evidence of professional liability insurance (which will be in effect as of the date of licensure) in compliance with Kansas law before a license will be issued. Each active license may be renewed annually. Licensees must maintain and submit evidence of satisfactory completion of a program of continuing education. Licensees must maintain and submit evidence of professional liability insurance, and contribute to the Kansas Health Care Stabilization Fund (more information about this fund can be found here: https://hcsf.kansas.gov/). A current active practice form and written agreement must be on file with the Board.

Federal Active ☐ A license issued to a person who meets all the requirements for a license to practice as a physician assistant and who practices as a physician assistant solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies. Each federal active license may be renewed annually. A current active practice form and written agreement must be on file with the Board. Individuals must maintain and submit evidence of satisfactory completion of continuing education hours.

Inactive ☐ A license issued to a person who meets all the requirements for a license to practice as a physician assistant and who does not engage in active practice as a physician assistant in the state of Kansas. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit a Responsible Physician and Drug Prescription Protocol. Individuals must maintain and submit evidence of satisfactory completion of continuing education hours.

Exempt ☐ A license issued to a person who is not regularly engaged in the practice as a physician assistant in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. The holder of an exempt license may serve as a paid employee or unpaid volunteer of a local health department as defined by K.S.A. 65-241, or an indigent health care clinic as defined by K.S.A. 75-6102. Each exempt license may be renewed annually. Individuals must maintain and submit evidence of satisfactory completion of continuing education hours. A current active practice form and written agreement must be on file with the Board.

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 license to practice as a physician assistant 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. Continuing Education
Include proof of completion of continuing education as required by K.A.R. 100-28a-16, if applicable.

12. Malpractice Insurance
Include proof of professional liability insurance and participation with the Kansas Health Care Stabilization Fund as required by K.S.A. 65-28a03(e), if applicable.

Application fee of $250 and NPDB report fee of $3. Make the fees payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

Applicant Name: _____
(please print or type

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

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.

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

SEAL here

Sworn to before me this _____day of

_____ 20 _____

_____ Notary Public

_____ Commission Expires

revised 1/15/13, 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

Physician Assistant
Active Practice Request Form
and Written Agreement

Please enter required information , including dates and signatures.
Mail form to KSBHA, 800 SW Jackson LL, Ste. A,. Topeka, KS 66612 or fax to 785-296-0852.

Please refer to the detailed instructions at the end of the form.

Section I - Physician Assistant Information

Physician Assistant's Name _____

Kansas License Number: _____ or Pending, application on file ☐

License Designation: Active ☐ Federal Active ☐ Exempt ☐

Reason for submitting form: New supervisory relationship ☐ New written agreement for an additional practice ☐
Modification of existing written agreement or replacement of previous *Responsible Physician and Drug Prescription Protocol* ☐

DEA Number: _____ N/A ☐

Section II - Kansas Supervising Physician Information

Name: _____ Kansas License Number: _____

Does the supervising physician engage in practice in Kansas? Yes ☐ No ☐

DEA Number: _____ N/A ☐ Specialty/Practice Area: _____

Describe methods of communication between supervising physician and physician assistant when not at the same location:

_____

Describe the procedure to be followed for addressing patient emergencies:

_____

Section III - Kansas Substitute Supervising Physician(s) Information (use additional pages if more than two).

Name: _____ Kansas License Number: _____

Does the substitute supervising physician engage in practice in Kansas? Yes ☐ No ☐

DEA Number: _____ N/A ☐ Specialty/Practice Area: _____

Name: _____ Kansas License Number: _____

Does the substitute supervising physician engage in practice in Kansas? Yes ☐ No ☐

DEA Number: _____ N/A ☐ Specialty/Practice Area: _____

Section IV - Written Agreement

Complete written agreement for **each** facility/practice location where medical services are provided by the physician assistant (use additional pages if more than one location).

A. Practice Location Information

Name of Facility/Location _____ Street Address _____ City and State _____ Zip Code _____

Is this Locum Tenens practice? Yes ☐ No ☐ If yes, anticipated Time frame: _____

Phone Number: _____

Practice Setting: Office Practice ☐ Clinic ☐ Hospital ☐ ASC ☐ Nursing Home ☐

Other ☐ _____

Is this a "different practice location" as defined in K.A.R. 100-28a-1(b)? Yes ☐ No ☐

If yes, are the requirements of K.A.R. 100-28a-14 met? Yes ☐ No ☐

Substitute Supervising Physician(s) for this location: _____

For this practice location, describe the procedure to be used to notify a substitute supervising physician of the supervising physician's absence or other unavailability: _____

B. Scope of Practice for this Location

Description of the scope of medical services and procedures that the Physician Assistant is authorized to perform at this practice location (use additional pages if necessary). _____

Do any of the medical services and/or procedures require a specific type of supervision by the supervising physician or substitute supervising physician as defined in K.A.R.100-28a-1a(c), (e) or (f)? Yes ☐ No ☐

If yes, please specify below:

Type of Supervision	Medical Services/Procedures
Direct	
Indirect	
Off-site	

If applicable, list any other restriction or exclusion on the Physician Assistant's authorized scope of practice: _____

DNR Order Authority? Yes ☐ No ☐

C. Prescription - Only Drug Authority for this location

The Physician Assistant is authorized to prescribe and administer **non-controlled** prescription drugs as follows:

All ☐ None ☐ All with Exceptions ☐

Specify Exceptions _____

Physician Assistant's Name: _____ Supervising Physician's Name: _____

Within the limitations set forth in K.S.A. 65-28a08(b)(2), the Physician Assistant is authorized to dispense **non-controlled** prescription drugs as follows: All ☐ None ☐ All with Exceptions ☐

Specify Exceptions _____

The Physician Assistant is authorized to distribute non-controlled, professional drug samples? Yes ☐ No ☐

The Physician Assistant is authorized to prescribe and administer **controlled substances** as follows:

	NONE	All	All EXCEPT, specify:
Schedule II and II-N	☐	☐	☐ _____
Schedule III and III-N	☐	☐	☐ _____
Schedule IV	☐	☐	☐ _____
Schedule V	☐	☐	☐ _____

Within the limitations set forth in K.S.A. 65-28a08(b)(2) and other applicable state and federal laws, the Physician Assistant is authorized to dispense **controlled substances** as follows:

	NONE	All	All EXCEPT, specify:
Schedule II and II-N	☐	☐	☐ _____
Schedule III and III-N	☐	☐	☐ _____
Schedule IV	☐	☐	☐ _____
Schedule V	☐	☐	☐ _____

Physician Assistant's DEA number to be used when practicing at this location (if different from page one): _____

Do the Supervising Physician and Physician Assistant have DEA registrations for all the schedules authorized above?
Yes ☐ No ☐

D. Attestations and Signatures for this Practice Location (use additional pages for signatures if more than 2 substitute supervising physicians)

*I confirm the medical services and procedures authorized are within the clinical competence and customary practice of the supervising physician and all substitute supervising physicians as required by K.A.R. 10-28a-10.
*I understand that the supervising physician or a substitute supervising physician shall be available for communication with the physician assistant at all times during which the physician assistant could reasonably be expected to provide professional services.
*I confirm that the supervising physician has established and implemented a method for the initial, periodic and annual evaluation of the physician assistant's professional competency required by K.A.R. 100-28a-10.
*I understand that failure to adequately supervise the physician assistant in accordance with the Physician Assistant Licensure Act or rules and regulations adopted under such statutes by the Board, shall constitute grounds for revocation, suspension, limitation or censure of a supervising physician's license to practice medicine and surgery in the State of Kansas.
*I confirm that a current copy of this form shall be provided to the Board office and maintained at the usual practice locations of the supervising physician and that any changes or amendments thereto will be provided to the Board within 10 days of being made.
*I have carefully read the questions in the foregoing request form and have answered them completely, and I declare under penalty of perjury that my answers and all statement contained herein are true and correct.

_____ Signature of supervising physician
_____ Date
_____ Signature of physician assistant
09012020 Date

_____ Signature of substitute supervising physician
_____ Date
_____ Signature of substitute supervising physician
_____ Date

Physician Assistant's Name: _____

Supervising Physician's Name: _____

Physician Assistant
Active Practice Request Form and Written Agreement
Instructions

General Information:

Many amendments to the Physician Assistant Licensure Act and temporary regulations became effective January 11, 2016, and greatly affect PA practice in Kansas. Those changes expanded scope of practice for PAs and increased the number of PAs that one physician can supervise. Consequently, increased information must be provided to the Kansas Board of Healing Arts about each supervisory relationship and practice location. Physicians and PAs should familiarize themselves with the statutes and regulations regarding PA practice and supervision. The information provided in these instructions should not be construed as legal advice or complete information about the requirements for PA practice and supervision. The statutes and regulations may be found on the agency website at **www.ksbha.org/statsandregs.shtml**

New Forms: PAs must now complete an "Active Practice Request Form" (APR form) as a condition of engaging in practice in Kansas. Effective January 11, 2016, the APR form replaces the "Responsible Physician and Drug Prescription Protocol" form. There is a "Written Agreement" section of the APR form which specifies the details of the PA's delegated practice authority at each practice location where the PA works.

PAs Practicing Under Old Forms: Currently practicing PAs who enter into a ***new*** supervisory relationship must complete an APR form prior to practicing. PAs currently practicing under an existing supervisory relationship who have previously submitted a "Responsible Physician and Drug Prescription Protocol" will have until July 1, 2016, to submit the new APR form and Written Agreement(s) for their existing practice locations.

General Instructions:

An APR form is required for ***each*** Physician-PA supervisory relationship. Additionally, the "Written Agreement" portion of the APR form is required for ***each*** location where the PA will practice under that supervisory relationship. The Written Agreement for each practice location requires information about the practice location, the scope of practice and prescription drug authority of the PA, and the substitute supervising physician for that specific location. PAs practicing at multiple locations will need to submit a Written Agreement for each separate location including office-practices, clinics, hospitals, nursing homes, surgery centers, hospice facilities, etc. Signatures of the PA, supervising physician and substitute supervising physician(s) must be on each Written Agreement.

New Practice Locations Added or Other Changes: Every time a new practice location is added, a new Written Agreement must be submitted to the Board within 10 days. Additionally, any other changes to the APR form must be submitted to the agency within 10 days of being made (examples- changes in scope of practice, prescribing authority, substitute supervising physician, types of supervision, etc.)

Names at bottom of each page: Please include the name of the PA and the Supervising Physician on each page of the form and on any supplemental pages in case the pages become separated. Pages submitted without this information will not be accepted.

Filling Out the Forms: The APR form and included pages for the Written Agreement are in a fillable PDF format. Information can be entered on the form and then printed and signed. Hand-written signatures are required. If additional space is needed to complete the information required in a section of the form, please attach supplemental pages. Incomplete forms will not be accepted.

You may wish to save your electronically filled-out PDF form on your computer so the information is readily available if amendments, additional practice locations, or changes in substitute supervisors need to be made in the future and submitted to the agency. If you hand-write the form, retain a working copy to be edited in the future if needed.

Section I- PA Information:

- Please provide all requested information for the Physician Assistant.
- Name- as it appears on license or application for licensure.
- Provide license number or indicate if a pending application has been submitted to the agency.
- Indicate if the PA's license designation is active or exempt (practice limited by K.S.A. 65-28a03(g))
- List the PA's DEA number if the PA will have controlled-substance drug authority.

Section II- Supervising Physician Information:

- Please provide all requested information for the Supervising Physician (M.D. or D.O.) who will delegate medical services and procedures to be performed by the PA and supervise the PA's practice.
- Name- as it appears on the Supervising Physician's license.
- Indicate whether the Supervising Physician practices in Kansas. Supervising Physicians are required to engage in the practice of medicine and surgery in Kansas pursuant to K.A.R. 100-28a-10(a)(1).
- List the Supervising Physician's DEA number if the PA will have controlled-substance drug authority.
- Provide the Supervising Physician's specialties or practice areas (cardiology, family practice, hospitalist, bariatrics, etc.) A Supervising Physician may only delegate acts which are within their clinical competence and customary practice.
- Indicate how the Supervising Physician and PA will communicate regarding patient care when both are not at the same location (phone, text, e-mail, etc.)
- Specify the agreed-upon plan the PA will follow if a patient has an emergency medical condition which requires treatment that exceeds the PA's authorized scope of practice or clinical competence.

Section III- Substitute Supervising Physician(s) Information:

- Please provide all requested information for **all** Substitute Supervising Physicians who have been designated by prior arrangement to provide supervision of the PA in the Supervising Physician's absence. This may be a single physician or multiple. Each Substitute Supervising Physician designated has the same requirements as the Supervising Physician when he/she is supervising the PA.
- Space on the form is provided to list two Substitute Supervising Physicians. Use additional pages to provide the requested information if there is more than two Substitute Supervising Physicians.
- Name- as it appears on the Substitute Supervising Physician's license.
- Indicate whether the Supervising Physician practices in Kansas. Substitute Supervising Physicians are required to engage in the practice of medicine and surgery in Kansas pursuant to K.A.R. 100-28a-10(a)(1).
- List the Substitute Supervising Physician's DEA number, if the PA will have controlled-substance drug authority.
- Provide the Substitute Supervising Physician's specialties or practice areas (cardiology, family practice, hospitalist, bariatrics, etc.).

Section IV- Written Agreement(s):

- A separate Written Agreement is required for ***each*** location where the PA will practice. Use additional pages if there is more than one practice location.

Subsection A- Practice Location Information:

- Complete address and telephone information about the specific practice location is required.
- Indicate if the PA's practice at the location is a locum tenens placement and the anticipated timeframe if known.
- Indicate they type of practice setting for the location.
- Indicate if the practice location is a “different practice location,” which is a practice location where the supervising physician is ***physically present*** less than 20% of the time services are provided at the location. It is important to note that “medical care facilities” defined in K.S.A. 65-425(h), such as hospitals, ambulatory surgery centers and rehabilitation centers, are ***not*** considered “different practice locations” even if the supervising physician is physically present less than 20% of the time services are provided to patients.
- If the location meets the definition of “a different practice location,” indicate whether the specific requirements of K.A.R. 100-28a-14 are met (PA has had 80 hours of direct supervision; a physician provides in-person care at the location at least once every 30 days; written notice that location is primarily staffed by a PA is posted where likely to be seen by patients).
- Specify who the Substitute Supervising Physicians are for the location.

• Describe the agreed-upon procedure for the Substitute Supervising Physician to be notified if the Supervising Physician is absent or unavailable (examples- standing agreement to cover on Wednesday mornings supervisor is in surgery; substitute is notified of PA's work hours each week and ensures availability by phone or text during those times; substitute is on clinic premises during all times PA works, etc.).

Subsection B- Scope of Practice for this Location:

• Describe the scope of practice delegated to the PA at the specific practice location.
• Indicate any delegated medical services or procedures which shall require specific types of supervision by the Supervising Physician or Substitute Supervising Physician. It is ***optional*** to require specific types of supervision for certain medical services or procedures performed by the PA. The different types of supervision are defined in K.A.R. 100-28a-1a as ***direct*** (physical presence of supervising physician or substitute), ***indirect*** (physical presence of supervising physician or substitute at site of patient care within 15 minutes), or ***off-site*** (supervising physician or substitute is immediately available by telephone or other electronic communication).
• If there are any other restrictions/exclusions to the PA's delegated scope of practice, they should be listed in the space provided on the form (examples- no self-prescribing, colposcopies, newborn care, etc.)
• Specify if the PA has authority to write DNR orders.

Subsection C- Prescription-Only Drug Authority for this Location:

• Indicate the PA's authority to prescribe, administer and dispense ***non-controlled*** prescription drugs in the corresponding sections on the form. If there are exceptions to the PA's authority, those should be explicitly specified.
• Please note that a PA's authority to dispense prescription drugs is limited by K.S.A. 65-28a08(b)(2). A PA may only dispense prescription drugs if pharmacy services are not readily available; dispensing is in the best interests of the patient; and the quantity of drugs dispensed do not exceed a 72-hour supply. Authority to dispense must be indicated on the Written Agreement.
• Indicate if the PA is authorized to distribute ***non-controlled*** professional drug samples at the practice location.
• Indicate the PA's authority to prescribe, administer and dispense ***controlled substance*** prescription drugs in the corresponding sections on the form. If there are exceptions to the PA's authority, those should be explicitly specified.
• List the PA's DEA number to be used when practicing at this location if different from the DEA number listed on the first page of the APR form.
• Indicate if the Supervising Physician and PA both have DEA registrations for all of the schedules of controlled substances the PA is authorized to prescribe, administer or dispense. A Supervising Physician cannot delegate authority that he or she does not have themselves.

Subsection D- Attestations and Signatures for this Practice Location:

• The PA, Supervising Physician and all Substitute Supervising Physicians for this location should carefully read each of the statements before signing.
• Dated signatures of the Supervising Physician, PA and Substitute Supervising Physician(s) are required. If there are more than 2 Substitute Supervising Physicians for this practice location, use additional pages.

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

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GENERAL INFORMATION AND INSTRUCTIONS

Please visit www.ksbha.org for all statutes and regulations governing the practice of a Physician Assistant.

Thank you for your interest in becoming licensed 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. **Do not** make a commitment to any work dates prior to being licensed.

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 at 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 information or documents in addition 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 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.

Kansas Application Fees must be submitted with the application and are **NOT** refundable. Kansas application fee is $250. 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, or credit card. To pay by debit or credit card please complete the credit card authorization form.

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 sent to the appropriate place to be completed and mailed directly to the Kansas Board of Healing Arts.

Each person applying for an active license must submit to the Board evidence of professional liability insurance and participation in the Kansas Health Care Stabilization Fund as required by KSA 65-28a03(e).

The National Practitioner Data Bank (NPDB) Report was mandated by Congress and tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. All applicants include a $3 report fee for the Board to obtain the NPDB report.

Licenses/Certificates expire January 31 and are renewed annually. License renewal will be required of all receiving a permanent license prior to November 1.

CHECK LIST - Did you complete the following?

ALL questions answered on the application
Request verification from states, countries or jurisdictions, if applicable
Documentation for any “YES” Attestation Questions
Head and shoulder photograph
Notarize and sign Oath
Notarize and sign Release
Provide proof of professional liability insurance or intent of coverage, if applicable
Complete Active Practice Request Form and Written Agreement, if applicable
Provide proof of continuing education, if applicable
Fees

revised 1/14/16, 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

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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