Kansas
State Board of Healing Arts

RESPIRATORY THERAPIST GENERAL INFORMATION

Thank you for your interest in becoming licensed in Kansas. 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 respiratory 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. 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 using the registration code listed in the MRL. When the license is issued, a notification with the wallet card is sent to the preferred email address.

If your license is issued before January 1, you will be required to renew during that year's renewal period. If your license is issued 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 RT licenses cancel May 1, if not renewed.

Fees:
Application**: $80**
NPDB: **$3**
Temporary Permit: **$25**
ALL FEES ARE NON-REFUNDABLE

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

Application Check List:

☐	Complete application with all questions answered.
☐	Request official transcript with final RT degree awarded be sent directly to the board.
☐	Request professional school complete the Letter of Completion if transcript with final degree is not available. (Temp permit only)
☐	Request verification of other licenses, permits or certifications, if applicable.
☐	Request NBRC scores be sent directly to the board.
☐	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.

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RESPIRATORY THERAPIST APPLICATION INSTRUCTIONS

Application Fees: The respiratory therapist application fee is $80, and the National Practitioner Data Bank (NPDB) fee is $3. The total payment of $83 must accompany the application. If requesting a temporary permit, please include the additional $25 fee. These *fees are* ***non-refundable*** and will be processed upon receipt. 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.

Temporary License: Temporary licenses are available for applicants who meet the requirements for licensure or applicants who meet all requirements for licensure but have not yet taken the National Board for Respiratory Care exam. Only one temporary permit may be issued, and the permit expires six months after the date of issuance. If applying for a temporary permit, a **Letter of Completion** will be accepted in lieu of an official transcript when all degree requirements have been met, and an official transcript is not yet available. The official transcript with final degree awarded must be received by the Board before a permanent license can be issued.

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.

Examination: If you have taken the NBRC examination and passed, provide the number of attempts and date passed. Board staff will internally verify certification. If you have not yet taken examination, check the corresponding box and list the date you are scheduled to sit for the exam. After becoming certified, request NBRC send the board an official credential verification letter by visiting https://practitionerportal.nbrc.org/directory/all. **The report must be received directly from NBRC.**

Postsecondary Education: In chronological order, list all postsecondary schools you have attended, even those from which you did not graduate. Attach additional page if necessary. Request an **official transcript with the final RT degree awarded** be mailed or sent electronically from the school directly to the Board. The Board also accepts electronic transcripts from official third-party vendors. Send electronic transcripts to KSBHA_Licensing@ks.gov.

Letter of Completion: The Letter of Completion will be accepted in lieu of an official transcript when all degree requirements have been met, and the official transcript with the final degree awarded is not yet available. Complete,

sign and date the top portion of this form. Request the school or program complete the bottom portion and return directly to the Board. A seal or notary is required, it must be clearly visible to be accepted by email. The Letter of Completion must be received directly from the school or program.

Employment/Professional History: In chronological order, list all employment/professional history for the past five years. Account for all months and explain all gaps. Attach additional page if necessary. Include the actual work address, not corporate headquarters. If you have not worked in the past five years check the corresponding box.

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 will be required to request a license verification. Please check with the licensing agency to see if a fee is required for this information. 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.

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.

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.

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.

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RESPIRATORY THERAPIST INITIAL 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**.** As a reminder, **please do not make a commitment to work dates, prior to being licensed.**

TEMPORARY LICENSE

Are you requesting a temporary license? (for applicants who have not yet taken NBRC examination or who have taken examination, but the official transcript is not yet available) Yes ☐ No ☐

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. 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:

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Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov

U.S. ARMED FORCES SERVICE

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

EXAMINATION

List all NBRC examination attempts and the date passed. If you have not tested check the corresponding box and list the date you are scheduled to sit for the exam.

Date Passed:	Number of Attempts:
I have not yet tested ☐	Date scheduled to sit for exam:

POSTSECONDARY EDUCATION

In chronological order, list all postsecondary schools you have attended, even those from which you did not graduate. Attach additional page if necessary.

College/University:			
City:	State:	Start Date:	End Date:
Degree Earned:		Date Awarded:	

College/University:			
City:	State:	Start Date:	End Date:
Degree Earned:		Date Awarded:	

EMPLOYMENT/PROFESSIONAL HISTORY

In chronological order, list all employment/professional history for the past five years. Account for all months and explain all gaps. Attach additional page if necessary. Include the actual work address, not corporate headquarters. If you have not worked in the past five years check the corresponding box.

I have not worked in the past five years ☐				
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.

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

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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:_____

   Is the relocation due to military orders? Yes ☐ No ☐
   If you answer "yes", provide a copy of the orders with your application.

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: _____

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*** "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).

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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 ☐

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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.

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AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION

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 respiratory therapist 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 respiratory 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 respiratory therapy.

Attach/Upload 2x3 Photo

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

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

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

NOTARY

State of _____, County of _____,
I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____day of _____, 20_____

Notary Public Signature _____ My Notary Commission Expires _____

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LETTER OF COMPLETION

For the purpose of obtaining a temporary license, the Letter of Completion may be submitted 3 weeks prior to graduation or any time after graduation, in lieu of an official transcript, when it is confirmed that all degree requirements have been met and the official transcript with the final degree awarded is not yet available.

Applicant: Complete the top portion and submit to the school or program.

School or Program: For the purpose of obtaining a temporary license, this form may be completed **3 weeks prior to graduation or any time after graduation, in lieu of an official transcript, when it is confirmed that all degree requirements have been met and the official transcript with the final degree awarded is not yet available.** Complete the bottom portion and email to KSBHA_Licensing@ks.gov or mail directly to the Kansas State Board of Healing Arts. The seal or notary must be clearly visible to be accepted by email.

I hereby authorize the school or program listed below to provide the Kansas State Board of Healing Arts any and all information pertaining to my education at that institution.

Full Name: _____

Other Names Used (if applicable): _____ Date of Birth: _____

Name of School or Program: _____

Signature: _____ Date: _____

TO BE COMPLETED BY THE PRESIDENT, REGISTRAR, DEAN OR DIRECTOR OF COURSE

Name of Applicant: _____

Name of School or Program: _____

Address: _____

Start Date: _____ Completion or Expected Completion Date: _____

Degree Awarded: _____

By signing below, I certify under penalty of perjury under the laws of the State of Kansas that the information provided is a true and correct statement of the record of the above-named applicant. It is further certified that the applicant completed all requirements according to the standard of accreditations prevailing at the time and will receive the above-stated degree.

_____ _____
Signature Date

_____
Printed Name & Title (Seal)

_____
Email

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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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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:**	**Amount:**
Purpose of Payment: *(Application, NPDB, KBI, Verification of License Fee, etc.) To view license Fee List, click here.*		
Name of Cardholder:		
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.