



## REINSTATEMENT APPLICATION FOR RESPIRATORY THERAPY

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 from 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.** Account for all time and explain all gaps in professional activity. 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) \_\_\_\_\_

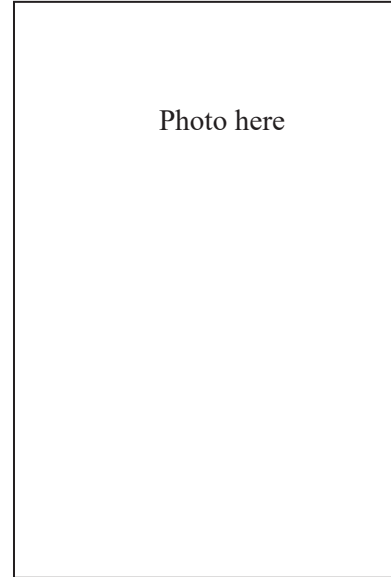
Location: \_\_\_\_\_ Dates: From \_\_\_\_\_ To \_\_\_\_\_  
city state mm/yy mm/yy

**7. List all states or jurisdictions in which you are currently or have ever been licensed, registered or certified as a respiratory therapist. 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 an RT 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.



**9. 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 respiratory therapist 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

**10. Continuing Education**

Include proof of completion of continuing education as required by K.A.R. 100-55-8, if applicable.

**Application fee of \$80 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)



## EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406<sup>i</sup>, 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.

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<sup>i</sup> 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

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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.

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Full Name of Applicant

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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 martialled 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

Sworn to before me this \_\_\_\_\_ day of

\_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_ Notary Public

\_\_\_\_\_ Commission Expires

SEAL here





## LICENSE VERIFICATION FORM

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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](mailto: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: \_\_\_\_\_

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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: \_\_\_\_\_



## THIRD PARTY RELEASE

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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](mailto:KSBHA_Licensing@ks.gov) or mail it directly to the Board.

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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



## GENERAL INFORMATION AND INSTRUCTIONS

Please visit [www.ksbha.org](http://www.ksbha.org) for all statutes and regulations governing a [Respiratory Therapy License](#).

Thank you for your interest in 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 some of the common excuses: "My attorney told me I don't have to disclose." or I did not think the prior act had anything to do with my profession or 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 \$80. 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 copied and sent to the appropriate place to be completed and mailed directly to the Kansas State Board of Healing Arts.

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 March 31 and are renewed annually. License renewal will be required of all receiving a permanent license prior to January 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 Form
- Proof of continuing education, if applicable
- Fees



## CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

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

### CREDIT CARD INFORMATION:

<b>Card Type:</b>				
<b>Card Number:</b>				
<b>Expiration Date:</b> (MM/YY)			<b>Verification Code:</b>	
<b>Purpose of Payment:</b> <i>(Application, NPDB, KBI, Verification of License Fee, etc.) To view license Fee List, <a href="#">click here.</a></i>				<b>Amount:</b>
<b>Name of Cardholder:</b>				
<b>Mailing Address</b>	Street Address:			
	City:		State:	Zip:
	Phone:		Email:	

### APPLICANT/LICENSEE INFORMATION:

<b>Name of Applicant/Licensee:</b>	<b>License Number:</b>
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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.