



RESIDENT ACTIVE DOCTOR OF OSTEOPATHIC MEDICINE AND SURGERY LICENSE RENEWAL (DO)

Complete this form to renew your Resident Active license from **August 15, 2025** to **October 31, 2025**. Renewals must be received postmarked on or before **October 31, 2025**. If not renewed, your license will cancel on **November 1, 2025**. Email the completed renewal to KSBHA_Licensing@ks.gov. It is highly recommended that you make and keep copies of all the items you submit.

FEE: \$100
ALL FEES ARE NON-REFUNDABLE

IDENTIFYING INFORMATION

First Name:	Middle Name:	Last Name:	Suffix:
License Number:	Current License Status:	NPI Number:	

ADDRESSES

Addresses cannot be a Post Office Box, except qualified participants under the Safe at Home Act, K.S.A. 75-451 *et seq.* Your home address will not be available to the public. The business address is public and will be posted on the Board's website. You may consider listing the postgraduate program as the business address. The Board will contact you at the preferred address. Provide any additional addresses at which you practice on a separate sheet.

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 ___			

PROFESSIONAL SERVICES DURING AN EMERGENCY

Are you willing to be included on a registry of potential volunteers to provide your professional services during an emergency? If you answer "yes", select all that apply:			Yes ___	No ___
Within the county of residence	Within 75 miles of residence	Anywhere in Kansas	Outside Kansas	

LANGUAGES YOU SPEAK

___ English	___ Spanish	___ ASL – American Sign Language	___ Other:
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U.S. ARMED FORCES SERVICE

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

LICENSES/PERMITS/CERTIFICATIONS

List all state or jurisdictions in which you currently, or have ever held, a license, permit or certification, permanent or temporary. Attach additional page if needed.

State	Issue Date	License Type	License Number

PRACTICE SPECIALTY & BOARD CERTIFICATION

Primary Specialty:	Secondary Specialty:
Board Certification:	Board Certification:

DEA NUMBER(S)

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KANSAS HOSPITAL PRIVILEGES (Active, Federal Active, and Exempt License Only). Attach additional page if needed.

Do you have Kansas hospital privileges? If you answer “yes”, provide the facility name.	Yes ___	No ___
Facility Name:	Facility Name:	

QUALIFYING STATEMENT

I certify that I am presently engaged in and in good standing in an approved postgraduate training program and maintain the qualifications required under Kansas law to hold a Resident Active license.	Yes ___	No ___
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PROFESSIONAL LIABILITY INSURANCE & KHCSF COMPLIANCE (Active License Only)

All MD, DO, DC, DPM and PAs with an active license in Kansas are required to maintain professional liability insurance of not less than \$500,000 per claim, and not less than \$1,500,000 annual aggregate for all claims made during the policy period, and are also required to maintain compliance with the [Kansas Health Care Stabilization Fund](#) (KHCSF). [K.S.A. 40-3402](#) [K.S.A. 40-3404](#); [K.S.A. 65-2809\(c\)](#); [K.S.A. 65-2005\(d\)](#); [K.S.A. 65-28a03\(b\)](#). For questions relating to how to comply with Fund requirements, please visit <https://hcsf.kansas.gov/>, or call (785) 291-3777, or email HCSF@ks.gov.

The Board will verify compliance with liability insurance requirements and fund compliance in an audit of an undetermined percentage of renewal applications. You must maintain your liability insurance records for a four-year period in a manner that allows them to be readily produced.

During the last 12 months, while holding an active license in Kansas, did you and do you continue to maintain professional liability insurance and compliance with the Kansas Health Care Stabilization Fund as required by Kansas law?	Yes ___	No ___
I certify that I have read and understand the liability insurance and KHCSF compliance audit process.	___	
Insurance Company:		
Policy Number:	Effective Date:	Expiration Date:

GRATUITOUS PROFESSION SERVICES (Active, Federal Active, and Exempt License Only)

Have you entered into an agreement with the Kansas Secretary of Health and Environment to gratuitously provide professional services to medically indigent persons or to conduct a children's immunization program administered by the Kansas Secretary of Health and Environment?	Yes ___	No ___
Have you gratuitously provided any professional services at a local health department or indigent healthcare clinic to a medically indigent person or a person receiving medical assistance from the programs operated by the Department of Health and Environment?	Yes ___	No ___
If you answered “yes” to either of the questions above, how many hours of gratuitous services to medically indigent persons have you provided within the preceding licensure period?	_____	
If you answered “yes” to either of the questions above, how many hours of continuing education credit (by the performance of two hours of gratuitous professional services to medically indigent persons per hour claimed), up to a maximum of twenty (20) hours of continuing education credit, are you claiming for this licensure period?	_____	

ATTESTATION QUESTIONS

If you answer “yes” to any of the questions and have not previously notified the Board a Response Form for each “yes” answer will be emailed to you. Please complete the form(s) and return to the Board.

1. In the past 12 months have you been and/or continued to be a defendant or has any judgment, award or settlement been paid on your behalf as a result of a professional liability claim/lawsuit?	Yes ___	No ___
1a. If you answered yes to question 1., have you previously notified the Kansas State Board of Healing Arts in writing about the lawsuit/judgment/award/settlement or received written communication from the Kansas State Board of Healings Arts about it? NA ___	Yes ___	No ___

2.	In the past 12 months have you been arrested, charged with or convicted of any misdemeanor, felony or the military equivalent? This includes a diversion or plea to any misdemeanor, felony or the military equivalent.	Yes ___	No ___
2a.	If you answered yes to question 2., have you previously notified the Kansas State Board of Healing Arts in writing about the arrest, charge, or conviction of any misdemeanor, felony, or the military equivalent or received written communication from the Kansas State Board of Healings Arts about it? NA ___	Yes ___	No ___
3.	In the past 12 months has any disciplinary action been initiated or taken against you by any state or government agency, or have you been denied a license, had any adverse action taken on your license, surrendered or consented to limitation of your license to practice in any state or country?	Yes ___	No ___
3a.	If you answered yes to question 3., have you previously notified the Kansas State Board of Healing Arts in writing about the initiation of or disciplinary action, denial of a license, adverse action, surrender, or limitation of your license to practice or received written communication from the Kansas State Board of Healings Arts about it? NA ___	Yes ___	No ___
4.	In the past 12 months have any privileges related to your profession as a health care provider been suspended, restricted, limited or voluntarily surrendered or has any peer review or professional association initiated or taken any action against you?	Yes ___	No ___
4a.	If you answered yes to question 4., have you previously notified the Kansas State Board of Healing Arts in writing about your privileges being suspended, restricted, limited, or voluntarily surrendered or any peer review or professional association initiation of or final action taken against you, or received written communication from the Kansas State Board of Healings Arts about it? NA ___	Yes ___	No ___
5.	Do you have any physical or mental health condition (including alcohol or substance use) that currently impairs your ability to practice your profession in a competent, ethical, and professional manner?	Yes ___	No ___
5a.	If you answered yes to question 5., have you previously notified the Kansas State Board of Healing Arts in writing about the physical or mental health condition that currently impairs your ability to practice your profession in a competent, ethical, and professional manner, or received written communication from the Kansas State Board of Healings Arts about it? NA ___	Yes ___	No ___
6.	In the past 12 months have you been the subject of any investigation, including in Kansas, regarding allegations, complaints, or charges by any state licensing agency or other government agency?	Yes ___	No ___
6a.	If you answered yes to question 6., have you previously notified the Kansas State Board of Healing Arts in writing about the investigation or received written communication from the Kansas State Board of Healings Arts about it? NA ___	Yes ___	No ___

MILITARY SPOUSE QUESTION

As of July 1, 2024, spouses of active-duty service-members who reside or plan to reside in Kansas due to their assigned military station or their spouse’s military station, are exempt from fees assessed by state licensing bodies to obtain or renew occupational credentials (2024 HB 2745). If you answer yes to the below question, no fee is required.

Are you the spouse of an active member of any branch of the United States armed services, United States military reserves, or national guard, and reside or plans to reside in Kansas due to the assigned military station of your spouse?	Yes ___	No ___
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VOLUNTARY PUBLIC STATEMENT

Pursuant to K.S.A. 65-28,131, the Board shall make available on our website which is accessible by the public, the following information regarding licensees:

- (1) Full name, business address, telephone number, license number, type, status and expiration date;
- (2) practice specialty and board certifications, if any;
- (3) any public disciplinary action taken against the licensee by the Board or by the licensing agency of any state or other country in which the licensee is currently licensed or has been licensed in the past;
- (4) any involuntary limitation, denial, revocation or suspension of the licensee's staff membership or clinical privileges at any hospital or other health care facility, and the name of the hospital or facility, the date the action was taken, a description of the action, including any terms and conditions of the action and whether the licensee has fulfilled the conditions of the action;
- (5) any involuntary surrender of the licensee's drug enforcement administration registration; and
- (6) any final criminal conviction or plea arrangement resulting from the commission or alleged commission of a felony in any state or country.

<p>At the time of licensure or renewal, a licensee <u>may</u> add a statement to such licensee's profile as it appears on the website created herein for the purpose of providing further explanation of any disciplinary information contained in your profile. Do you wish to add a statement to further explain any disciplinary information contained in your public profile?</p>	<p>Yes ____</p>	<p>No ____</p>
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If you answer “yes”, your statement will need to be emailed to KSBHA_PublicStatement@ks.gov within 30 days of your license cancellation date. Please note, not all public statements are posted or posted in full, to comply with Kansas and Federal law.

OATH

Pursuant to K.S.A. 65-28,131, information provided herein may be deemed public and may be posted on our Website. Failure to furnish the Board any information legally requested by the Board may be deemed unprofessional conduct and may be the basis for disciplinary action. Pursuant to K.S.A. 65-28,126, licensees are required to notify the Board in writing within 30 days of any changes in the licensee's mailing and/or practice address. By this submission, I hereby certify that I am the licensee named in this renewal application or have been authorized by that person, and I have personally submitted all data requested in the renewal

application form. I understand that Kansas law allows the Board to revoke, suspend or limit a license, censure the license, or impose a fine in an amount up to \$5,000 for any act of fraud or misrepresentation in applying for renewal of a license. I declare, under penalty of perjury, under the laws of the state of Kansas, that the foregoing is true and correct.

Name of person completing renewal

Signature of person completing renewal

Date



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

APPLICANT/LICENSEE INFORMATION

Name of Applicant/Licensee:	License Number:
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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.