



## POSTGRADUATE TRAINING YEAR 3 VERIFICATION

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For purposes of meeting postgraduate training requirements under K.A.R. 100-6-2, this form may be used to expedite licensure for applicants who are currently in their third year of postgraduate training and have secured employment.

If this form is utilized, it is the applicant's responsibility to ensure the Postgraduate Training Verification (UA Form #3) indicates successful completion and is submitted to the Board no later than 30 days from the program's end date.

If the Postgraduate Training Verification (UA Form #3) is not received, you shall be subject to discipline.

### Applicant:

Complete the top portion and submit to your current Program Director of the postgraduate training program.

### School/Program:

This form may be completed **45 days prior to the expected completion date; when it is confirmed that the applicant will successfully complete all postgraduate training requirements.** Complete the bottom portion and email to [KSBHA\\_Licensing@ks.gov](mailto: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.

Further, by signing below, I also warrant that I will inform the Kansas State Board of Healing Arts if for any reason I do not successfully complete the Postgraduate Training Program as scheduled.

Full Name: \_\_\_\_\_

Other Names Used (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of School or Program: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### TO BE COMPLETED BY THE PROGRAM DIRECTOR OR DESIGNATED OFFICIAL

Name of Applicant: \_\_\_\_\_

Name of School or Program: \_\_\_\_\_

Address: \_\_\_\_\_

### Postgraduate Training Year: 3

Training Type:  Internship  Residency  Fellowship  Research  Other: \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Will Successfully Complete  Yes  No

Accredited By:  ACGME  AOA  RCPSC  CFPC  RACS  Other: \_\_\_\_\_



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**If any “yes” answers, please provide a detailed explanation on a separate sheet.**

1. Did this individual ever take a leave of absence or break from training? Yes\_\_\_ No\_\_\_
2. Was this individual ever placed on probation? Yes\_\_\_ No\_\_\_
3. Was this individual ever disciplined or under investigation? Yes\_\_\_ No\_\_\_
4. Were any negative reports for behavioral reasons ever filed by instructors? Yes\_\_\_ No\_\_\_
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes\_\_\_ No\_\_\_

By signing below, I warrant and swear under penalty of perjury that the information provided is a true and correct statement of the record of the above-named applicant. It is further warranted that the applicant will complete all training requirements.

Further, I understand and agree it is the programs responsibility to notify the Board prior to program completion if the above warranted information changes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name & Title

\_\_\_\_\_  
Email

(Seal)