



## GENERAL INFORMATION PHYSICAL THERAPIST (PT) AND PHYSICAL THERAPIST ASSISTANT (PTA)

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 Physical 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](mailto:KSBHA_Licensing@ks.gov). If a seal or notary is required, it must be clearly visible to be accepted by email. **Pages 1-3 of the application will not be accepted handwritten.** KSBHA highly recommends that you make and keep copies of all the items you submit to the Board. As a reminder, **please do not commit 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 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 a license or permit is issued a notification with the wallet card is sent to the preferred email address.

**If your license is issued before November 1, you will be required to renew during that year’s renewal period. If your license is issued after November 1, you will not be required to renew until the next year’s renewal period. Renewal starts November 15; late renewal starts January 1. All PT/PTA licenses expire January 31.**

**Fees:**

- Application: **\$80**
  - Criminal Background Report: **\$57**
  - NPDB: **\$3**
  - Temporary Permit (optional): **\$25**
- ALL FEES ARE NON-REFUNDABLE**

If you:	Then complete the:
Never held a Kansas Physical Therapy license	Initial Application
Previously held a Kansas Physical Therapy license that is now cancelled	Reinstatement Application

**PT/PTA Application Requirements Check List:**

Complete application with all questions answered.
Request official transcript with final PT/PTA degree awarded directly from the school.
Request the Letter of Completion if transcript with final degree is not available. (Temporary permit only)
Request verification of other licenses, permits or certifications, if applicable.
Request electronic verification from FSBPT.
Provide documentation for any “YES” answers to the Attestation Questions.
Complete Expedited Licensure Questionnaire.
Notarize and sign the Affidavit and Authorization.
Complete jurisprudence exam. (PTs Only)
If foreign trained, request a credential evaluation from FCCPT or ICD
If foreign trained, provide documentation that the language of instruction was English or current TSE/TOEFL certificate.
Complete Criminal Background Check Waiver and Fingerprint card.
Provide documentation of name change, if applicable.
Complete and sign the Third-Party Release, if applicable.

For frequently asked questions, visit: <https://www.ksbha.ks.gov/departments/licensing/licensing-faqs/physical-therapist>



## APPLICATION INSTRUCTIONS – PHYSICAL THERAPIST (PT) AND PHYSICAL THERAPIST ASSISTANT (PTA)

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### Application Fees

Application fees must be submitted with the application. These *fees are non-refundable* and will be processed upon receipt. The Kansas PT/PTA application fee is **\$80**, criminal background report fee is **\$57**, and the National Practitioner Data Bank (“NPDB”) report fee is **\$3**. **Total fees due are \$140**. The temporary permit is optional and is an additional **\$25**. All fees must accompany the application.

Board staff directly run the background check and NPDB report for all applicants. **Please do not submit an NPDB self-query**. To pay by debit or credit card, complete the Credit Card/Debit Card Authorization Form. The form can be submitted with the application. If paying by check or money order, please make it payable to the KSBHA. Checks/money order must be mailed to the Board. Checks returned for any reason by the payer’s financial institution must be replaced by a money order, certified check, or credit card.

### Temporary Permit

A temporary permit is available for applicants who meet the requirements for licensure or have not yet taken or passed the National Physical Therapy Examination (“NPTE”). **Only one temporary permit may be issued**, and the permit expires three 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 Kansas Board of Healing Arts (“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.

### 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

Cannot use a P.O. Box as your address unless you qualify under the Safe at Home Act (K.S.A. 75-451 *et seq.*). Your home address will be kept private. Your business address is public and will appear on the Board’s website. If you do not have a business address, check the box provided.

The Board will contact you using your preferred mailing and email address. If any of your contact information changes, you must notify the Board within 30 days by submitting a [Change of Address Form](#) or updating it 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**

List all NPTE examination attempts. Request FSBPT send the Board an electronic official score report by visiting <https://www.fsbpt.org/Our-Services/LicenseeServices/ScoreTransferService>. **The verification must be received directly from FSBPT.** If you have not tested check the corresponding box and list the date you are scheduled to sit for the exam.

### **Postsecondary Education**

List all postsecondary schools you have attended in chronological order, including schools you did not graduate from. Use an additional page if needed.

Request that your school send an official transcript showing your final PT/PTA degree awarded directly to the Board, either by mail or electronically. The Board also accepts electronic transcripts from approved third-party vendors. Send electronic transcripts to [KSBHA\\_Licensing@ks.gov](mailto: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. This form may be completed no more than 3 weeks prior to graduation or any time after graduation, in lieu of an official transcript.

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**

List all employment/professional activities from the past five years in chronological order. Include explanations for any gaps, such as being a student or unemployed. If you have not practiced in your profession within the past five years, please provide the date you last actively practiced.

Use additional pages if needed. Be sure to list the actual work location addresses, **not corporate headquarters**. If you have not worked at all in the past five years, check the box provided.

### **Other Licenses/Permits/Certifications**

List every state or jurisdiction where you currently hold or have ever held a healthcare license, permit, or certification—whether permanent or temporary. If you have never held one, check the box provided.

The Board will verify your credentials for any state that offers free, up-to-date verification on its official website, including issue date, expiration date, and any disciplinary actions. If the Board cannot verify your credentials online, you must send the Verification Form to each licensing agency. Check with each agency to see if they charge a fee before sending the form.

The Board accepts electronic verifications sent directly from the licensing agency or their approved third-party vendor. Send electronic verifications to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov).

### **Attestation Questions**

The application includes several attestation questions. Answering “yes” does not automatically disqualify you, as each case is reviewed individually. However, all “yes” answers must be fully explained on a separate signed page. Include complete details—such as dates, locations, reasons, outcomes—and attach any relevant documents.

The Board will verify all information and may ask for additional details. You must update the Board if anything changes after you submit your application. Failure to fully disclose information may result in denial of your application.



### **Criminal Background Check Report**

As of December 01, 2025, Physical Therapists (PTs) and Physical Therapist Assistants (PTAs) must submit fingerprints for state and national background checks. Instructions are available on the Fingerprint and Background Check Instructions page.

Fingerprint processing can delay your application, so complete it as soon as possible. You must also complete, sign, and send the Waiver Agreement and Statement form directly to the Board, along with the \$57.00 fee.

### **Affidavit and Authorization for Release of Information**

Sign and date this form in front of a notary public. Your photo must be clear and in color taken from the shoulders up within the last 90 days. Black-and-white, AI-generated, or poor-quality photos will not be accepted.

### **Jurisprudence Exam (PTs)**

Complete the jurisprudence exam and return it with your application. Answers can be found in the [Statute and Regulation Handbook](#).

### **PROFESSIONAL LIABILITY INSURANCE (PTs)**

[K.S.A. 65-2920](#) and [K.A.R 100-29-15](#) requires PTs with an active license in Kansas to maintain professional liability insurance of not less than \$100,000 per claim, and not less than \$300,000 annual aggregate for all claims made during the policy period.

### **Credential Evaluation (Foreign Trained)**

Request a credential evaluation from the Foreign Credentialing Commission on Physical Therapy (FCCPT) or International Consultants of Delaware (ICD).

### **TOEFL Certificate (Foreign Trained)**

Any applicant who received training at a school where English was not the primary language of instruction shall provide one of the following:

- Official documentation that the primary language of instruction in the physical therapy program was English;
- A current Test of English as a Foreign Language – Internet based testing (TOEFL iBT) certificate in which the applicant has obtained a minimum of the following in each section: Writing 24, Speaking 26, Reading 21, and Listening 18.

### **Third Party Release (Optional)**

Complete this form if you would like Board staff to discuss your application process with third parties.

### **Expedited Licensure Questionnaire (Optional)**

To determine if you are eligible for expedited licensure pursuant to [K.S.A. 48-3406](#), complete the questionnaire and submit with your application.

### **How to Check the Status of Your Application**

Once your application is received and processed, a missing requirement letter (“MRL”) will be sent via email. This letter will list missing items and instructions on how to check the status of your application online.



**PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT (PTA)  
INITIAL LICENSURE APPLICATION**

Completed application and forms can be emailed to [KSBHA\\_Licensing@ks.gov](mailto: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. Reference **Application Instructions** for detailed information.

**TYPE OF LICENSURE**

Type of licensure/certification you are requesting: Physical Therapist (PT) ____ Physical Therapist Assistant (PTA) ____
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**TEMPORARY LICENSE**

Are you requesting a Temporary Permit? Yes ___ No ___
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**IDENTIFYING INFORMATION**

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**

Cannot use a P.O. Box as your address unless you qualify under the Safe at Home Act (K.S.A. 75-451 *et seq.*).

Home Address	Street Address:		
	City:	State:	Zip:
	Phone:	Email:	
Business Address No 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):
<input type="checkbox"/> A qualified alien (as defined in 8 U.S.C.A § 1641.
<input type="checkbox"/> A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A § 1101 <i>et seq.</i>
<input type="checkbox"/> An alien who is paroled into the United States under 8 U.S.C.A § 1182(d)(5) for less than one year.
<input type="checkbox"/> A foreign national, not physically present in the United States.
<input type="checkbox"/> Other:

**U.S. ARMED FORCES SERVICE**

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

**NATIONAL PROVIDER IDENTIFIER (NPI)**

I do not have an NPI Number ___	NPI number:
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**OTHER LICENSES/PERMITS/CERTIFICATIONS**

I have <b>never</b> held a healthcare related license, permit or certification in another state or jurisdiction. ____			
State	Issue Date	License Type	License Number

**LICENSE DESIGNATION (PTs Only)**

Review each description carefully and select the appropriate license designation you are requesting.

Active ____	Engaged in the practice of Physical Therapy. Required to complete continuing education and maintain professional liability insurance.
Federal Active ____	Engaged in the practice of physical therapy solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies. Required to complete continuing education. <b>Not</b> required to maintain professional liability insurance.
Exempt ____	Does <b>not</b> regularly engage in the practice of physical therapy and does not hold oneself out to the public as being professionally engaged in such practice. Entitled to all the privileges of physical therapy and may serve as a paid employee or unpaid volunteer of (A) A local health department as defined by K.S.A. 65-241 or (B) an indigent health care clinic as defined by K.S.A. 75-6102. Required to complete continuing education. Not required to maintain professional liability insurance.
Inactive ____	<b>Not</b> engaged in the practice of the physical therapy and does not hold oneself out to the public as being professionally engaged in such practice. Required to complete continuing education. <b>Not</b> required to maintain professional liability insurance

**PROFESSIONAL LIABILITY INSURANCE (PTs Only)**

[K.S.A. 65-2920](#) and [K.A.R 100-29-15](#) requires PTs with an active license in Kansas to maintain professional liability insurance of not less than \$100,000 per claim, and not less than \$300,000 annual aggregate for all claims made during the policy period.

I certify that I have read and understand the professional liability insurance requirements while holding an active license in Kansas.	____
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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 | ___ |



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.\****



**AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION**

**Applicant:** In the presence of a notary public, sign and date this form with attached photo. Email completed form to [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or mail 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 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 contained in this application.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction.

**Applicant  
Photograph**  
  
Attach a color photograph of applicant, with head and shoulder areas only, taken within the last 90 days.

\_\_\_\_\_  
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 \_\_\_\_\_



## FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS

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A criminal background check is required prior to issuance of licensure. Be aware that fingerprint processing may delay your application. **Please make it a priority to complete the fingerprint process.**

Following is the Waiver Agreement and FBI Privacy Act Statement. Please complete, sign and date the top portion of this form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Please visit <https://www.nbinformation.com/locations/locationMap.php> for a listing of fingerprinting locations.

Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the fingerprints must be printed on the fingerprint card and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov) or call (785) 296-7413.

Complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submission. Include name, aliases, complete mailing address, social security number, citizenship, date of birth, and personal information (sex, race, height, weight, eyes, hair, place of birth). The spaces for OCA, FBI and MNU numbers can be left blank. Cards with missing or incomplete information will be rejected and must be resubmitted.

Mail the completed Waiver Agreement and fingerprint card to the Board. You may want to use a mailing service that allows for delivery confirmation.

Kansas State Board of Healing Arts  
Attn: Licensing  
800 SW Jackson St., Suite 700  
Topeka, KS 66612  
Phone: (785) 296-0934  
Email: [KSBHA\\_Licensing@ks.gov](mailto:KSBHA_Licensing@ks.gov)

Fingerprint results are valid for 6 months from the date received. Applications for licensure completed after the 6-month period will be required to submit a new Waiver Agreement, fingerprint card, and \$57 fee.

**WAIVER AGREEMENT  
AND  
FBI PRIVACY ACT STATEMENT**

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) Kansas State Board of Healing Arts to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. The fingerprints are authorized to be submitted under the authority of the National Child Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law (Pub. L.) 103-209 and Pub. L. 105-251. Pursuant to K.S.A. 22-4701 et seq., K.S.A. 22-5001, K.S.A. 75-712i, and 2022 Kansas Laws Ch. 92, § 1 (Senate Sub. for H.B. 2495), the Authorized Recipient may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the above-referenced Authorized Recipient of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Authorized Recipient may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities until the criminal history background check is completed.

I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose of challenging the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. See 5 United States Code (U.S.C.) 552a(b); 28 U.S.C. 534(b); 34 U.S.C. 40316, Article IV(c); 28 CFR 20.21(c), 20.33(d), 906.2(d); and 2022 Kansas Laws Ch. 92, § 1 (Senate Sub. for H.B. 2495).

I understand that my fingerprints will be retained by the KBI and/or the Federal Bureau of Investigation if the Authorized Recipient participates in the state or national Rap Back program for continued suitability for being an employee, volunteer or contractor, or eligibility for any license, certification, registration, or adoption. The Rap Back program will notify the Authorized Recipient when there are updates to my criminal history record. Once I am no longer employed, a volunteer contractor, licensed, certified, registered, or seeking adoption, the Authorized Recipient shall request my fingerprints be removed from the state and/or national Rap Back program.

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**FBI PRIVACY ACT STATEMENT**

**Authority:**

The FBI's acquisition, preservation, and exchange of identification records and information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous federal statutes, hundreds of state statutes pursuant to Pub. L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub. L. 94-29; Pub. L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

**Social Security Account Number (SSAN).**

Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 U.S.C. 552a), the Authorized Recipient is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also requires federal agencies to use this number to help identify individuals in agency records.

**Principal Purpose:**

Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted

**WAIVER AGREEMENT  
AND  
FBI PRIVACY ACT STATEMENT (Cont.)**

information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

**Routine Uses:**

The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 U.S.C. 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

**Additional Information:**

The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

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**RIGHT TO OBTAIN AND CHALLENGE ACCURACY  
OF CRIMINAL HISTORY RECORDS**

*You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness at no cost.*

**To Challenge Your Kansas Criminal History Record Information (CHRI)**

You may also obtain a copy of your Kansas CHRI to review for accuracy and completeness, by submitting a set of your fingerprints, a letter requesting your criminal history record, and payment of the appropriate fee to the KBI. If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license, certification or registration, or adoption.

For further details, including the current fee, visit the following Internet website: [http://www.kansas.gov/kbi/info/info\\_brochures.shtml](http://www.kansas.gov/kbi/info/info_brochures.shtml) then find the brochure named "Record Checks for Non-Criminal Justice Purposes".

**To Challenge Your National Criminal History Record Information (CHRI)**

To obtain a copy of your national CHRI, also known as the Identity History Summary, for review and challenge you must submit a set of your fingerprints and the appropriate fee to the FBI. The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34).

Information regarding this process may be obtained at: <https://www.fbi.gov/services/cjis/identity-history-summary-checks>.

**DO NOT SEND THIS FORM TO THE FBI**

**WAIVER AGREEMENT  
AND  
FBI PRIVACY ACT STATEMENT (Cont.)**

I have \_\_\_\_ **OR** have not \_\_\_\_ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under K.S.A. 21-5903.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information about how to challenge my criminal records for accuracy and completeness.

Signature	Date		
Printed Name	Date of Birth		
Residential Address	City	State	Zip

**TO BE COMPLETED BY THE FINGERPRINTING AGENCY:**

Method of Verifying Identity:	<input type="checkbox"/> Driver's License	<input type="checkbox"/> State Issued ID Card
	<input type="checkbox"/> Military ID Card	<input type="checkbox"/> Passport
State/Branch: _____	ID Number: _____	

Agency Name: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of Individual Verifying Identity: \_\_\_\_\_

<p><b><i>APPLICANT: Please return all pages to the Authorized Recipient</i></b></p> <hr/>
<p><b><i>AUTHORIZED RECIPIENT: 1. Must maintain the original or arrange for KBI to maintain. 2. Must provide a copy to the applicant.</i></b></p>

**DO NOT SEND THIS FORM TO THE FBI**



## KANSAS PHYSICAL THERAPIST JURISPRUDENCE EXAM (PTs Only)

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All Physical Therapist: Complete the jurisprudence exam and submit with your application. A score of 80% or higher is required. Each question is given a weight of four (4) percentage points. Answers are available in the [Physical Therapy Statute and Regulation Handbook](#).

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Full Name of Applicant

Date

1. Which is NOT part of Kansas Statute 65-2901, (hereafter called the Kansas Physical Therapy Practice Act), definition of physical therapy?
  - a. Examining, evaluating and testing individuals
  - b. Alleviating impairments, functional limitations and disabilities
  - c. The practice of any branch of the healing arts
  - d. Fabrication of orthotics, debridement and wound care, manual therapy.
  
2. Which professional designation is not legal for introductions or business cards/public address in Kansas?
  - a. Dr. Jane Doe, physical therapist
  - b. Jane Doe, PT, DPT
  - c. Dr. Jane Doe, DPT
  - d. Dr. Jane Doe
  
3. Which is NOT part of obtaining a temporary permit to practice in Kansas?
  - a. Submission of an application on a form sent to the Board of Healing Arts
  - b. Meeting all requirements for licensure as a physical therapist (PT), or certification as a physical therapist assistant (PTA)
  - c. Payment of a temporary permit fee, which expires three months after date of issue
  - d. Obtaining additional temporary permits
  
4. Which is NOT one of the requirements for licensure renewal applications?
  - a. 20 continuing educational hours for PTs and 10 for PTAs every two years.
  - b. Notice of conviction of felony, fraud, incompetence, or unprofessional conduct.
  - c. Updates to the Board of Healing Arts on correct address and work setting within 30 days of change
  - d. Proof of professional liability insurance policy, except for inactive license
  
5. Which is NOT one of the reasons licenses may be refused or sanctioned, suspended or limited?
  - a. Failure to refer patients to other providers if symptoms are beyond physical therapy scope of practice
  - b. Addiction to, or distribution of, intoxicating liquors or drugs for other than lawful purposes
  - c. Knowingly submitting any deceptive or untrue claim, bill or statement
  - d. Treating human beings as authorized by the Kansas Physical Therapy Practice Act
  
6. Which would NOT be considered unprofessional conduct that results in a sanction of license?
  - a. Failing to provide adequate supervision to a PTA or other person who performs services pursuant to delegation by a physical therapist.
  - b. Promising a patient a permanent cure for an incurable disease, condition or injury.
  - c. Changing jobs too frequently.
  - d. Advertising a guarantee of any professional physical therapy service.
  
7. What is NOT part of the definition of unprofessional conduct?
  - a. Charging excessive fees for services performed
  - b. Treating two or more patients at one time
  - c. Providing treatment unwarranted by the patient's condition or continuing beyond reasonable benefit
  - d. Committing any act of sexual abuse or misconduct



8. Supervision of a PTA by a PT includes all of the following EXCEPT:
  - a. Notification by the PTA to the Board of Healing Arts of each supervising PT's name and license number
  - b. On-site personal supervision of aides, technicians, or paraprofessionals by the PT, or PTA under the direction of the PT, being immediately available to support personnel.
  - c. Support personnel may be delegated skilled professional care of patients beyond basic "tasks" if given on-site instructions
  - d. Consideration of the education, training, experience and skill level of the physical therapist assistant
  
9. The Kansas Physical Therapy Practice Act specifically states that the supervising physical therapist must supervise each physical therapist assistant working under his or her direction and supervision. How often must the physical therapist see each patient treated by the physical therapist assistant?
  - a. A minimum of every 30 days
  - b. A minimum of every two weeks
  - c. A minimum of weekly
  - d. Neither the Statutes nor the Rules and Regulations specify a specific time frame, except when a PTA initiates treatment after phone consultation with the PT
  
10. The Kansas State Board of Healing Arts can now impose a fine on a Physical therapist for a first offense not to exceed:
  - a. \$100
  - b. \$5,000
  - c. \$10,000
  - d. \$500
  
11. Under the Kansas Physical Therapy Practice Act, which of the following are NOT within the scope of physical therapy practice?
  - a. Laser surgery
  - b. Anodyne treatment
  - c. Electromyography
  - d. Nerve conduction velocity testing
  
12. Physical therapists can evaluate and treat, without a referral from a licensed care professional, in all cases EXCEPT:
  - a. Wound debridement
  - b. Employees solely for the purpose of work-place injury prevention
  - c. Special education students as part of an IEP or IFSP
  - d. In a hospital outpatient PT department
  
13. Physical therapists may evaluate and treat a patient, without a referral from a licensed health care professional, for no more than 10 visits or 15 business days after initial treatment EXCEPT:
  - a. Patient was provided written diagnosis that physical therapist cannot make "medical diagnosis"
  - b. In a hospital outpatient physical therapy department
  - c. Patient has demonstrated objective, measurable or functional improvement
  - d. All of the above
  
14. Which statement is a description of an appropriate activity for a PTA?
  - a. Interpretation of a referral, followed by performance and documentation of initial examination, testing, evaluation, diagnosis, and prognosis
  - b. Provision of physical therapy treatment interventions following an established plan of care
  - c. Development or modification of a plan of care that is based on a reexamination of the patient or client that includes the physical therapy goals for intervention
  - d. Documentation of the patient's discharge summary



15. Physical therapists are required to countersign notes written by physical therapists and physical therapist assistants who are working under a temporary permit.
  - a. True
  - b. False
16. Physical therapists and physical therapist assistants who have temporary permits must have direct supervision by a licensed physical therapist until they pass the appropriate PT or PTA national examination.
  - a. True
  - b. False
17. According to the Kansas Physical Therapy Practice Act, physical therapists are not allowed to delegate parts of the skilled physical therapy treatment to physical therapy aides.
  - a. True
  - b. False
18. Physical therapist assistants can write the discharge summary for a patient (e.g., a summary of treatments, patient progress, goals met, prognosis for further increase in function, etc.).
  - a. True
  - b. False
19. Physical therapists are required to carry malpractice insurance in the amount of 1 million/3 million.
  - a. True
  - b. False
20. In a sports medicine clinic, it is appropriate for a physical therapist assistant who is also an athletic trainer to evaluate and treat a patient and bill for it as physical therapy.
  - a. True
  - b. False
21. If I know a physical therapist or physical therapist assistant is practicing unethically or illegally, and do nothing about it, I am in violation of the Kansas Physical Therapy Practice Act.
  - a. True
  - b. False
22. According to Kansas Rules and Regulations, it would be considered unprofessional conduct for a PTA to allow his/her patients to refer to him/her as "my physical therapist".
  - a. True
  - b. False
23. It is unprofessional conduct for a physical therapist or a physical therapist assistant to refer a patient or a client to a health care entity for services if the PT or PTA has a significant investment interest in the health care entity, unless the patient/client is informed in writing of the significant investment interest and that the patient/client can obtain services elsewhere.
  - a. True
  - b. False
24. The PT Advisory Council currently consists of three PTs, a physician, and a member of the Kansas State Board of Healing Arts.
  - a. True
  - b. False
25. Physical therapists may provide services without a referral to special education students who need physical therapy services to fulfill the provisions of their individualized education plan or individualized family service plan.
  - a. True
  - b. False



## 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](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.

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



### EXPEDITED LICENSURE QUESTIONNAIRE

The Kansas State Board of Healing Arts processes three kinds of expedited licenses under K.S.A. 48-3406: 1) Military Servicemembers; 2) Spouses of Military Servicemembers; and 3) an individual who has or intends to establish residency in Kansas. To determine eligibility for expedited licensure pursuant to K.S.A. 48-3406, please answer the following questions. Responses that are intentionally false or misleading, will subject the applicant to an administrative disciplinary action in Kansas and be reported to all appropriate state/federal/military/law enforcement agencies.

#### Military

Yes  No Are you or have you been a member of the military, including the military reserves or National Guard?

Current Military Servicemember. Military ID: \_\_\_\_\_ Branch: \_\_\_\_\_

Former Member with honorable Discharge. Military ID: \_\_\_\_\_ Branch: \_\_\_\_\_

#### Military Spouse

Yes  No Are you the spouse of a current or former military member, including the military reserves or National Guard?

Spouse of former member with honorable discharge. Military ID: \_\_\_\_\_ Branch: \_\_\_\_\_

Spouse of an Active Military member. Military ID: \_\_\_\_\_ Branch: \_\_\_\_\_

#### Residence

Yes  No Do you currently reside in KS?

Military Spouse residing in Kansas due to assigned military station of spouse.  
Assigned Military Station \_\_\_\_\_ Date of Assignment \_\_\_\_\_  
Current Residence \_\_\_\_\_

Military Member: Current Residence \_\_\_\_\_

Non-Military Member: Current Residence \_\_\_\_\_

#### Intending to Reside

Yes  No Do you intend to establish residency in KS within the next 6 months?

Military Spouse establishing residency due to assigned military station of spouse.  
Assigned Military Station \_\_\_\_\_ Date of Assignment \_\_\_\_\_  
Expected Date of Commencing Residency \_\_\_\_\_

Military Member: Expected Date of Commencing Residency \_\_\_\_\_

Non-Military Member: Expected Date of Commencing Residency \_\_\_\_\_

#### Supplemental Question

Yes  No Are you seeking a license in Kansas to practice a discipline in which you hold a current license in another State and have actively practiced in that discipline for at least two years immediately preceding this application?

“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.

State \_\_\_\_\_ License # \_\_\_\_\_



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.

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



## 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>Amount:</b>
<b>Purpose of Payment:</b> <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.