Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
**David B. Fye, JD** Executive Director

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
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www.ksbsrb.ks.gov
**Laura Kelly**, Governor

## APPLICATION INSTRUCTIONS FOR LICENSURE THROUGH RECIPROCITY

## *Licensed Specialist Clinical Social Worker*

1. *To apply for the Kansas LSCSW through reciprocity, you must hold, in another state, an active clinical social work license, or independent social work license which allows for the diagnosis and treatment of mental disorders independently.*

2. **Criminal Conviction/s -** You are required to report the following convictions:
   **A**. Conviction of any felony
   **B**. Conviction of any misdemeanor crime against a person

   Either of the above listed convictions will require you to complete the Conviction Packet. You may click on this link to download the: Conviction Packet or you may find this packet on our website, www.ksbsrb.ks.gov under forms. You must return the required documentation with your application packet. ***Your application will not be reviewed without this information*.** Your application will require a determination from the full Board on eligibility for licensure. **Please allow extra time for a decision to be made on your application.**

3. **Email.** The BSRB requires you that you provide an email address. Email is the Board's primary method of communication. If you change your email address, update your information with the Board office right away.

4. **Requirements for Licensure Through Reciprocity**

   **A.** Standards of your state's requirements are substantially equivalent to the Kansas requirements for licensure as a master social worker. Kansas requirements are:
      **i.** An MSW degree from a CSWE accredited program, or a program that meets the regulatory requirements found in K.A.R. 102-2-6.
      **ii.** Passed the ASWB exam at the Master's level or above.

*If you do not meet the above requirements, please contact the Board office, as there is an alternative route to licensure.*

   **B.** Absence of disciplinary action of a serious nature brought by a registration, certification, or licensing Board.
   **AND**
   **C**. *In addition to the requirements in A and B above*, you must also demonstrate competency in the diagnosis and treatment of mental health disorders, found in the DSM 5, by submitting at least two of the following items acceptable to the board:
      **i.** Have passed the ASWB clinical exam. Submitted directly to the Board office by ASWB or as part of the Verification of Licensure.
      **ii.** Have engaged in three years of clinical practice that included diagnosis or treatment of mental disorders**.** This practice must have included at least 8 hours of client contact per week for nine months or more of each year in your clinical practice. This practice may have been completed as an employee or in private practice. Submit Attachment A.
      **iii.** An attestation that the applicant has demonstrated competence in diagnosis or treatment of mental disorders, which shall be signed by either a professional licensed to practice medicine and surgery or another professional licensed to diagnose and treat mental disorders in independent practice. – Submit Attachment B.

5. **Verification of License:** The Board must receive a verification of license from every state or jurisdiction in which you hold, or have held a license, certificate, or registration. This verification must come from the other state board directly to the BSRB., Exceptions are made when the other state agencies will not send written verifications. Within the reciprocity application packet, you will find a License Verification form for your use. If the BSRB does not receive

information regarding your education and passing of the ASWB clinical exam, you will be required to have the following documents sent directly to the Board office.

**A**. An official transcript sent directly from your college or university to the Board office.

**B**. An official score report sent directly from the ASWB to the Board office.

*These documents will not be accepted if submitted by the applicant rather than the issuing institutions.*

**6. Fees:**

**A. Application Fee**. Submit the application along with the $50.00 application fee. You may pay by check, money order, credit card, or cash. Checks and money orders should be made payable to "Behavioral Sciences Regulatory Board" or "BSRB". **All Fees Are Non-Refundable.** Applications received without the application fee will not be processed.

**B. Original Licensure Fee.** You will be required to pay an Original License fee before your license will be issued. The fee for the original license, will be requested when you have been approved for licensure.

You will receive an email conformation when your application has been received and entered in our system. Included in this email is a user ID number that will be used to create an account in the system. This will allow you to follow your application online and see which documents have been received and what is still needed.

Applications are reviewed on a first come first served basis. We are unable to expedite any applications. (except military)

A completed application means: All documents required for your application have been received in the BSRB office.

___ Application
___ Application fee
___ Verification of License/s
Education Information/Transcript
Examination Information/ASWB Score Report
___ Attachment A or Attachment B

**Allow 30 days for review of your *completed* application packet.**

You may check the status of your application on our website www.ksbsrb.ks.gov, under *"Services / Application Status Check." Or click this link:* HTTPS://KSBSRB.KS.GOV/SERVICES/ONLINE-APPLICATION-STATUS-CHECK

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## LICENSURE APPLICATION THROUGH RECIPROCITY (LSCSW)

**Application Fee Required: $50 check, money order or credit card made payable to BSRB**

This application is only for applicants who are licensed, registered, or certified in another state to practice clinical social work and are applying under the reciprocity statute.

### I. Identifying information: (Please type or print clearly in ink)

**Legal Name:** _____ _____ _____
**Last** **First** **Middle**

**Maiden/Other names used:** _____ **Gender**: _____

**Date of Birth:** _____ **Social Security Number:** _____ (**Note:** Your social security number is required pursuant to 42 U.S.C.S. § 666(a)(13), K.S.A. 74-148 and K.S.A. 74-139, and may be used for child support enforcement purposes or provided to the Kansas director of taxation upon request.)

**Preferred E-Mail Address:** _____ **Preferred Mailing:** Home____ Business____

**Home Phone:** _____ **Cell Phone (optional):** _____

**Home Address:**_____ **Apartment Number:**_____

**City:** _____ **State:** _____ **Zip+4:**_____

**Business Phone:** _____ **Business Name:** _____

**Business Address:** _____ **Suite Number:** _____

**City:** _____ **State:** _____ **Zip+4:**_____

**A.** Are you a military servicemember (a current member of any branch of the United States armed services, United States military reserves or national guard of any state, or a former member with an honorable discharge) Yes____ No____
(If yes, please provide a copy of your military ID, a copy of your DD-214, or other proof of military service.)

**B.** Are you a military spouse (the spouse of a military servicemember)? Yes____ No____
(If yes, please provide a copy of your military ID, DD-214, or other proof of military service.)

**C.** Have you established residency in the State of Kansas? Yes____ No____

**D.** If no, do you intend to establish residency in the State Kansas? Yes____ No____
**If "Yes"** please explain:

_____
_____

### II. Information on Previous Licensure

Do you currently hold a certificate, registration, or license to practice clinical social work in another state or jurisdiction? Yes____ No____

**If "NO", you are not eligible to apply for the LSCSW through reciprocity. Please contact the Board office for other options to obtain a license.**

**If "YES" Please answer the following questions for each state where you hold/held a license, certificate, or registration. Attach a separate sheet, if necessary.**

**A.** Under what name: _____

**B.** State: _____ License Type: _____ License Number: _____

**C.** Date Issued: _____ Expiration Date: _____ Were there breaks in licensure? _____

**If this license was not continuous, what** dates where you **NOT** licensed: _____

**D.** Does this license allow you to practice independently, including the diagnosis and treatment of mental disorders? Yes ____ No ____

**We must receive Verification of Licensure, from <u>every</u> state in which you hold, or have held, a professional license, certification, or registration. This is not limited to clinical social work.**

## III. Information on Kansas Licensure and/or applications for licensure

**A.** Have you ever held a professional license in the state of Kansas? Yes____ No____
**If "yes", please answer the following questions:**

**1.** Under what name: _____

**2.** License Type: _____ Date Issued: _____ Expiration Date: _____

**B.** Have you ever filed any application for licensure or registration in Kansas for which you did not obtain a license? Yes____ No____

**If "yes", please answer the following questions:**

**1.** Under what name:_____

**2.** License Type: _____ Date of application:_____

## IV. Clinical Competence Choices

It is required that you submit information to show clinical competence in diagnosing and treating mental disorders found in the DSM 5. You must submit least two of the following three items below.

**Please check which <u>two</u> items in the boxes below you will be submitting for your application for clinical social work license. You cannot be licensed as an LSCSW without completing this section.**

**1.** _____ **Examination -** *If you are using passage of the ASWB clinical level exam*

a. Have you passed the ASWB Clinical Level Examination: Yes____ No____

b. Through what state or jurisdiction: _____ c. Date exam was taken: _____

*Request verification of your passing score from your state of licensure* OR *from the ASWB. Scores must be sent to the Board office directlv from the ASWB.*

**2.** _____ ***Three years of clinical practice diagnosing or treating mental disorders found in the DSM 5* - Attachment A**
*Specific hour requirements are found on the form.*

a. Did your work supervisor complete Attachment A? Yes____ No_
**If so**, what is the name of the supervisor? _____

b. Did you complete Attachment A? Yes____ No____
**If so,** did you provide proof of private practice (list of options found on Attachment A)
Yes____ No____

**3.** _____ **Attestation from a person who is licensed to practice at the independent/clinical level, attesting to your skills and competence in diagnosing and/or treating mental disorders - Attachment B**

Name of person completing Attachment B: _____

## V. Education:

**Provide the requested information regarding your graduate social work degree:**

**A.** Institution: _____

**B.** Major and or Concentration: _____ Degree Received: _____

**C.** Date Degree conferred: _____

**D.** Was this a CSWE accredited Program? Yes____ No____

## VI. Merit of the Public Trust:

**A.** If you answer yes to question 1 and/or 2, regarding convictions, you are required to complete the Conviction Packet. Click on this link to download Conviction Packet or you may find this packet on our website, www.ksbsrb.ks.gov under forms. See # 2 in the instructions.

1. Have you ever been convicted of a felony? Yes____ No___
2. Have you ever been convicted of a misdemeanor crime against a person? Yes____ No____

**B.** If you answer "Yes" to any of the following questions, ***you are required to submit as part of your application a signed, dated, type-written explanation that gives specific details including disposition of the matter.***
*Your application will not be processed without this information.*

1. Have you ever had a complaint filed with a professional association or a certifying, licensing, or registering body against you for alleged unethical behavior or unprofessional conduct? Yes____ No____
2. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct, or any other grounds? Yes__ No
3. Have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years? Yes____ No __
4. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years? Yes____ No____
5. Have you used controlled substances which were obtained illegally, or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years? Yes____ No____
6. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes____ No____
7. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit? Yes____ No____
8. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital, or state institution for the mentally retarded, or (3) an adult? Yes____ No____

## VII. Applicant's Attestation:

1. I have reviewed the licensure eligibility requirements prior to submitting this application. Yes____ No____
2. I have completed the application materials and procedures honestly and in good faith. Yes____ No____
3. I understand that the members and staff of BSRB are compelled by law to uphold, implement and enforce the licensure statutes and regulations as written. Yes____ No____
4. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but any such research will not personally identify the applicants or licensees, either directly or indirectly. Yes____ No____

5. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a BSRB form required for licensure or licensure renewal. Yes____ No____

6. I **have read** and am familiar with the appropriate statutes and regulations governing the practice of the professional license for which I am applying. Yes____ No____

7. I understand that **once the Board receives my application I am bound by, and will abide by, the statutes and regulations** governing the profession of the license for which I am applying Yes____ No____

Signature:_____Date:_____

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## APPLICATION FOR LICENSURE THROUGH RECIPROCITY

# *Verification of Licensure*

**Instructions:**
Section 1 is to be completed by the applicant and sent to the state or jurisdiction in which a license, registration, or certification is held or has been held. Additional copies of this form may be made and used as needed by the applicant.
Section 2 is to be completed by a representative of your licensing board and returned directly to the Behavioral Sciences Regulatory Board.

## I. SECTION 1: This section is to be completed by the applicant:

A. Name:_____

B. Other names used: _____

C. Social Security #:_____Date of Birth:_____

D. License Type:_____

E. License Number:_____

F. Date of Issuance :_____Date of Expiration: :_____

## II. SECTION 2: This section is to be completed by the State Board. Upon completion, please return this form to: BSRB, 700 SW Harrison St., Ste. 420, Topeka, KS 66603-3929.

A. Type of Credential: Licensure_____ Registration _____ Certification_____

B. License Type: _____ License Number:_____

C. Original Issue Date: _____Date of Expiration: _____

D. Did license ever lapse or expire prior to date of expiration listed in letter "C"? **Yes ___ No ____**

If yes, please explain: _____

E. Level of Lic/Reg/Cert (Baccalaureate, Masters, Doctorate): _____

F. Does this license allow independent practice including the diagnosis and treatment of mental health disorders? **Yes ___ No ____**

G. Is Lic/Reg/Cert in Good Standing? **Yes____No____**

If **"no"**, please state reason(s):

_____

_____

_____

H. Has the license ever been suspended or revoked? **Yes____ No____**

If **"yes",** please state reason(s): _____

_____

J. Has the license ever been surrendered voluntarily in lieu of an investigation? **Yes____ No____**

If **"yes",** please state reason(s): _____

_____

K. **Degree Information:**

1. Institution: _____
2. Degree Received:_____ Date Degree conferred: _____
3. Was this degree received from a CSWE accredited Program? **Yes____ No____**

L. **Examination Information:**

1. Name of examination taken: _____
2. Through what state or jurisdiction: _____ Level of exam taken: _____
3. Date exam was taken: _____ Exam Passed? **Yes____ No____**

N. **Additional Comments**:

Signature of State Board Representative: _____ Date: _____

Printed Name: _____

Official Title/Position: _____

State or Jurisdiction: _____

Agency: _____

Mailing Address: _____

Phone Number: _____ Fax Number:_____

Email Address: _____

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# *APPLICATION FOR LICENSURE THROUGH RECIPROCITY*

## *Attachment A – Three Years of Clinical Practice*

If you provided clinical services in an independent, private practice setting when you completed the three years of clinical experience, please complete Section A and attach appropriate documentation, as listed below and return the form with your application for licensure.

If you were an employee when you completed the three years of clinical experience, please skip section A and have your work supervisor complete section B. The supervisor should return the completed form to you in a sealed envelope with their signature across the seal. You will submit the form in the unopened, signed envelope with the rest of your application materials.

**The three years of clinical practice must have occurred AFTER your clinical/independent level of license was issued. Hours prior to that cannot be used to meet this requirement.**

**Applicant Name** _____

**A. Independent Practice**: If you worked in an independent practice setting, please complete the following:
Name of Agency _____ Phone _____

Address of Agency _____ City_____ State_____ Zip_____

I _____, attest that I have engaged in a minimum of 3 years of independent clinical practice which included diagnosis and treatment of mental disorders, with at least eight hours of direct client contact per week for at least nine months of each year.

**Check which one of the following forms of documentation you are submitting with your application for LSCSW:**

_____ Published job description,
_____ Description of your practice in a public information brochure,
_____ Description of services in an informed consent document, or
_____ A similar published statement demonstrating you have engaged in independent clinical practice for a minimum of 3 years **OR**
_____ An attestation signed by a professional licensed to practice medicine and surgery, or a licensed psychologist, a licensed specialist clinical social worker, or a professional licensed to diagnosis and treat mental disorders in independent practice.

Signature of Applicant _____ Date_____

Printed Name of Applicant _____

**B. Instructions for Supervisor**: Please complete section B and return to the applicant in a sealed envelope with your signature across the seal.

Name of Employer _____

Address of Employer _____
Street City State Zip

Employer Phone _____ Employer Fax _____

Applicant's Position/Title _____

Applicant's Lic/Reg/Cert Type _____ Applicant's Work Dates _____
Start Date End Date

**Continued**

Does the applicant have at least 3 years of clinical practice that included diagnosis or treatment of mental disorders?
**Yes ____ No ____**

**If yes**, did the applicant conduct at least 8 hours of client contact per week for 9 months or more of each year?
**Yes ____ No ____**

**If no,** how many client contact hours completed per week, per year? _____

Work Description: _____

_____

_____

Supervisor's Lic/Reg/Cert: Type: _____ Number: _____

I have been personally acquainted with the applicant **for _____ years.**

I attest that the applicant _____**is** _____**is not** competent in diagnosis and treatment of mental disorders.

I attest that the foregoing information supplied by the applicant is true to the best of my knowledge I believe the applicant to be of good professional character and worthy of confidence.

Supervisor Signature _____ Date _____

Printed Name of Supervisor: _____

**Please return this form to the application in a sealed envelope with your signature across the seal.**

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# *APPLICATION FOR LICENSURE THROUGH RECIPROCITY*
## *Attachment B - ATTESTATION FROM A LICENSED PROFESSIONAL*

**Instructions to Applicant:** This form should be completed by a person whose license allows the licensee to diagnose and treat mental disorders in independent practice. The referencing individual should return the completed form to you in a sealed envelope with their signature across the seal. You will then submit the form in the unopened envelope with the rest of your application materials.

**Name of Applicant** _____

**Instructions to Referencing Individual Completing the Form:** The above-named individual is applying for licensure in the State of Kansas. Please provide a written response attesting to this individual's competency to diagnose and treat mental disorders. Return the completed form to the applicant in a sealed envelope with your signature across the seal.

Information regarding the person completing this form.

Name of Referencing Individual: _____ License Type: _____

License Number: _____ Email Address: _____

A. Business Name: _____ Phone:_____

B. Business Address: _____
Street Address City State Zip

C. Are you related by blood or marriage to the applicant? Yes ____ No _____
**If yes**, state relationship: _____

D. How long have you known the applicant? _____

E. In what work setting have you known the applicant, include name of agency:_____
_____

F. What relationship (such as supervisor or co-worker) have you had with the applicant which has aided you in forming your opinion of his/her competence to diagnose or treat mental health disorders: _____
_____

G. Are you aware of any significant facts concerning the applicant's background which would reflect unfavorably on the applicant's character and fitness to practice as a clinical social worker? Yes ____ No ____
**If yes**, please state these facts as fully as possible on a separate sheet of paper.

H. In your opinion is the applicant competent to diagnose or treat mental disorders found in the DSM 5?
Yes ____ No _____

I. What evidence can you provide related to the applicant's competence to diagnose or treat mental disorders? Include amount and length of experience. (Feel free to expand on a separate sheet of paper if needed).
_____
_____

**Reference's Attestation:** I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining the applicant's competence to diagnose and treat mental disorders in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable

Reference's Signature: _____ Date: _____

**Please return form back to applicant in a sealed envelope with your signature across the seal.**

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# *Appendix A*

## *Payment Instructions*

**1.** Individuals wishing to submit payments to the BSRB using a credit card or electronic check should:

(1) visit the BSRB website at ksbsrb.ks.gov
(2) select the "SERVICES" drop-down tab from the top of the home screen, and
(3) click on the "Make A Payment" link. From this page, you will be asked to provide information allowing us to identify the applicant, select the item you wish to pay for, and you will be able to make a payment for that item.

For use of the secure payment platform, the state of Kansas charges a 2.5 percent processing fee for credit card payments or a $1.50 flat fee for use of an electronic check. After completing payment, you will receive a confirmation e-mail to confirm your payment.

**2.** Individuals wishing to submit payments to the BSRB office using a check-by-mail or with a money order may continue to mail payments to the Behavioral Sciences Regulatory Board, 700 SW Harrison St., Ste. 420, Topeka, KS 66603. There is no additional fee for processing checks-by-mail or money orders sent to the BSRB office.

The application fee may be paid before or after you submit your application. The application will not be processed until the fee has been received.