

Sam Brownback
Governor
Max L. Foster, Jr.
Executive Director



700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
(785) 296-3240
Fax: (785) 296-3112
www.ksbsrb.ks.gov

NOTICE OF AUDIT

Your renewal has been randomly selected for audit during this renewal period.

Please complete the enclosed Continuing Education tracking form. You will use this form to list the Continuing Education Units (CEUs) you have completed during the previous 24 month period.

It is required that you submit documentation for the CEUs you wish to claim. Please send the ORIGINAL documents for all CEUs and retain copies for your records. ***PLEASE NOTE***, if you would like the ORIGINALS returned, you must enclose a self addressed, stamped envelope. We shred all documents once the audit has been reviewed and approved.

For additional information on acceptable CEUs and acceptable documentation, please refer to the regulations related to your profession on our website at www.ksbsrb.ks.gov

If you don't hold a clinical license, you will also need to complete the Verification of Current Employment form.

You have until the last day of the month following your license expiration date to complete and submit your audit materials to the Behavioral Sciences Regulatory Board. If the audit information is not postmarked by this date, you may be found in violation of the Kansas Statutes regulating your profession.

Please ensure all of the following materials are returned:

- Continuing Education tracking form.
- ORIGINAL documents for all CEUs being claimed.
- The Employment Verification Form (for all non-clinical licensees only).

Your expiration date will not change on our website and you will not be issued a new wallet card reflecting your new expiration date until your audit has been completed.

Your license will remain active through this audit period per K.S.A. 77-511.

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Name: _____

License number and Level: _____ Expiration: _____

This form is to be submitted by all licensees who have been selected by the random audit procedure. Please return the completed and signed form along with the **ORIGINALS** of all continuing education documentation, to the board office.

Copies of this form may be made if necessary if you run out of room for documenting your continuing education hours.

As part of the continuing education hours required for each renewal cycle, each applicant shall complete 3 hours of continuing education on professional ethics focusing on ethical issues of their profession.

Additionally, each applicant, except LAC and LBSW, shall complete 6 hours of continuing education on diagnosis and treatment of mental disorders or if LCAC diagnosis and treatment of a substance abuse disorder.

*** If you are a social worker renewing this level of licensure for the first time, 6 hours of social work safety training is required.**

Title of course / workshop Or other CE activity:	Date(s) of attendance	Type of activity workshop/college course	Presenter	Hours Claimed
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Professional Ethics:

Diagnosis and Treatment:

*** Social Work Safety Training (required for first time social work renewals at any level):**

Title of course / workshop Or other CE activity:	Date(s) of attendance	Type of activity workshop/college course	Presenter	Hours Claimed
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Other Continuing Education:

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EMPLOYER'S VERIFICATION OF CURRENT EMPLOYMENT AND DIRECTION
(For all non-clinical licensees)

SECTION I For Social Work Licensees: This section is to be completed by the social work renewal applicant who is licensed at the bachelor or masters level license, is not seeking licensure as an LCSW and has been selected for audit.

Please print.

Name of renewal applicant: _____ License Type and # _____

Employer: _____

Employing Agency Address: _____

Name of Supervisor: _____ Title _____

Signature of Supervisor _____ Date _____

SECTION II For LMFT's, LMLP's & LPC's: This section is to be completed by the renewal applicant who is required to be under directed practice and has been selected for audit. Licensees who have a masters level license and who are **NOT** seeking licensure at the independent practice level of their discipline must be under direction "Providing direction," means providing professional monitoring and oversight of therapeutic relationships including regular periodic evaluation of treatment provided to a client or patient.

Please print.

Name of renewal applicant: _____ License Type and # _____

Employer: _____

Employing Agency Address: _____

Name of Supervisor: _____ Title _____

Are you licensed by a Kansas Board other than the BSRB? Yes No If yes, License Type and # _____

Board Name _____

Signature of Supervisor _____ Date _____

RENEWAL APPLICANT PLEASE READ CAREFULLY BEFORE SIGNING ATTESTATION

I understand that in signing this document I am attesting that the information is accurate. I further understand it is unlawful to attempt to obtain licensure through false statements or fraudulent misrepresentation. I understand that upon proof of fraud, deceit, or any other act of unprofessional conduct in relationship to my licensure renewal application the board may suspend, limit, revoke, condition, fine or refuse to renew my license.

Applicants Signature: _____ Dated this _____ day of _____ 20____.