

**SAM BROWNBACK**  
Governor

**MAX L. FOSTER, JR.**  
Executive Director



700 S.W. Harrison St. Ste 420  
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(785) 296-3240  
FAX (785) 296-3112  
[www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov)

## INSTRUCTIONS FOR LICENSURE APPLICATION THROUGH RECIPROCITY

1. Before you begin to complete the application form enclosed herein, please read all instructions and review the statutes and regulations so that you will understand exactly what information is being requested. The statutes and regulations can be found on our website, [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov). **Your must hold an active license in another state to apply for licensure through reciprocity.**
2. Answer all questions on the application completely and accurately. The burden of proof in satisfying to the Board that you are eligible for licensure is upon you. Thus, if you have been convicted of a felony or if there have been other past or current events that potentially raise questions about your ability to merit the public trust, you may be required to appear before the Board to explain these matters.
3. The \$100.00 application fee must accompany your application. Your check or money order should be made payable to "Behavioral Sciences Regulatory Board" or "BSRB". **ALL FEES ARE NON-REFUNDABLE.**
4. As part of the application process, you are required send **Attachment A = Out-Of-State Clearance form** to each of the licensing boards or jurisdictions you hold, or have held, a mental health professional license. The licensing agency should complete the form and return it directly to the board office.
5. Depending on your profession and which type of license you are applying for there are some differences in what is required for each license and even what level of license you are applying for. Please be sure to review the statutes and regulations for a detailed explanation.
6. **Masters Level Psychology (LMPL), Professional Counselors (LPC), Marriage and Family Therapy (LMFT)**
  - Option 1** – Standards of your state's requirements are substantially equivalent to Kansas requirements for licensure, registration or certification. See HB 2234 "new section" for Masters Level Psychology, See K.S.A. 65-5807 (a)(1) for Professional Counseling, K.S.A. 65-6406 (a)(1) for Marriage and Family Therapy.
  - Option 2** – A – Continuous registration, certification or licensure to practice your profession during the five years immediately preceding the date of application for reciprocity with Kansas with the minimum professional experience required by the board.
    - (1) Minimum professional experience is determined to be at least 15 hours of work experience per week for 9 months during each of the 5 years immediately preceding the date of application. Submit an attestation which is Attachment B of this application with your application.
      - B – Absence of disciplinary action of a serious nature brought by a registration, certification or licensing board. This will be attested to on Attachment A and should be completed by your licensing agency.
      - C – a masters degree in your profession from a regionally accredited university or college.
7. **Clinical Psychotherapist (LCP), Clinical Professional Counseling (LCPC), and Clinical Marriage and Family Therapy (LCMFT)**
  - A. In addition to the requirements listed in #6 after meeting option 1 or 2, you must also demonstrate the ability to diagnosis and treat mental disorders through at least two of the following areas acceptable to the board:
    1. Satisfactory completion of 15 graduate credit hours supporting diagnosis or treatment of mental disorders; **OR**
      - a. LCP's must demonstrate at least 3 of the 15 hours in a discrete course of psychopathology. The remaining 12 shall consist of diagnostic assessment, interdisciplinary referral and collaboration, treatment approaches and professional ethics. See Section VII of this application.
      - b. LCPC's must demonstrate at least 2 of the 15 hours in a discrete psychopathology course and 2 discrete hours in a professional ethics course. The remaining 11 shall consist of diagnostic assessment, interdisciplinary referral and collaboration, treatment approaches and professional ethics. See Section VII.
      - c. LCMFT's must demonstrate at least 3 of the 15 hours in a discrete course of psychopathology. The remaining 12 shall consist of diagnostic assessment, interdisciplinary referral and collaboration, treatment approaches and professional ethics. See Section VII of this application.
    2. Passed a national clinical examination approved by the board. See Section VI of this application.
  - B. You must submit one or both of the following types of documentation which will need to cover a period of at least 3 Years;
    1. An attestation by a supervisor or other designated representative of your employer that you have had at least 3 years of clinical practice, including at least 8 hours of client contact per week during 9 months or more of each year in a community health center or its affiliate, a state mental hospital, or another employment setting in which you engaged in clinical practice that included diagnosis or treatment of mental disorders—Use Attachment B; **OR**
    2. An attestation that the applicant has demonstrated competence in diagnosis or treatment of mental disorders That is signed by a professional licensed to practice medicine and surgery, or by a professional licensed psychologist, a licensed specialist clinical social worker, or another professional licensed to diagnose and treat mental disorders in independent practice – Use Attachment C.

## 8. Social Work at LBSW and LMSW Level

1. Submit verification of your license, registration or certification from your licensing board. Use Attachment A and be sure the form is mailed by the board directly to the Kansas BSRB.
2. Submit verification that the requirements for licensure, registration or certification to practice social work in your jurisdiction are substantially the same to Kansas requirements. This information is also included on Attachment A.
3. In addition to 1 and 2, submit verification of passage of an examination similar to the examination required under Kansas requirements. This can be sent from the licensing agency on Attachment A, or sent directly to the Kansas board office from the testing service. Please complete Section VI of this application.

## 9. Licensed Specialist Clinical Social Work

**Option 1** – Standards of your state's requirements are substantially equivalent to Kansas requirements for licensure, registration or certification. See K.S.A. 65-6309.

**Option 2** – Continuous registration, certification or licensure to practice your profession during the five years immediately preceding the date of application for reciprocity with Kansas with the minimum professional experience required by the board;

A – Minimum professional experience is determined to be at least 15 hours of work experience per week for 9 months during each of the 5 years immediately preceding the date of application. Please submit Attachment B with your application;

B – Absence of disciplinary action of a serious nature brought by a registration, certification or licensing board. This will be attested to on Attachment A and should be completed by your licensing agency;

C – a masters or doctoral degree in social work from a CSWE accredited university or college. This will be included on Attachment A;

D – verification of passage of a clinical examination approved by the board if licensed less than 10 years in another state or jurisdiction. This will be included on Attachment A.

Please complete section VI of this application as well; *Exempt if licensed 10 years or more*

E – You must show that you have had at least 3 years of clinical practice, including at least 8 hours of client contact per week, during 9 months or more of each of the 3 years. The 3 years need have occurred in an employment setting in which you engaged in clinical practice that included diagnosis and treatment of mental disorders. If you had a supervisor this person may complete Attachment B. If you were in private practice you may complete Attachment B and include appropriate supporting documentation, as described on the form.

## 10. All Applicants:

Be sure your application for licensure through reciprocity that you are submitting to the board includes the following:

- application completed by applicant;
- out of state clearance form submitted directly by your state or jurisdiction which you hold a lic/reg/cert;
- other forms of documentation required, depending on which method you are applying through (Attachment B, C, etc.);
- transcripts sent directly from the university or college to the board office to verify 15 hours of graduate academic hours for clinical levels of licensure;
- \$100.00 application fee

Please allow 30 days for review of your application. You may now **check the status of your application on our website** [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov), under "Applicants."

*The board office will contact you by mail regarding the status of your application. Be sure the board office has current contact information on file for you. It is the applicant's responsibility to notify the Board in writing of any name or address change that might occur during the application process.*

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**LICENSURE APPLICATION THROUGH RECIPROCITY**

**Application Fee Required: \$100 check, money order or credit card made payable to BSRB**

This application is only for applicants who have been previously licensed in another state and are applying under the reciprocity statute.

Please be sure to review the requirements for your profession, there are differences among the different professions which include different required documentation.

**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: \_\_\_\_\_

Address of Record: (Note: The address of record is not required. It is a separate address that will be kept on file to be given out when requested by the public through the Kansas Open Records Act. If you do not indicate an address of record, your preferred mailing address will be used.)

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_

**II. Application for Licensure**

A. What type of credential/license are you applying for through reciprocity ? \_\_\_\_\_

*(Licensed Psychologist, Licensed Masters Level Psychologist, Licensed Clinical Psychotherapist, Licensed Marriage and Family Therapist, Licensed Clinical Marriage and Family Therapist, Licensed Professional Counselor, Licensed Clinical Professional Counselor, Licensed Specialist Clinical Social Worker- see website for details [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov) )*

B. Are you applying for the **independent, clinical level of licensure** which allows you to diagnosis and treat mental disorders without being under supervision? Yes \_\_\_\_\_ No \_\_\_\_\_

**III. Information on Previous Licensure:**

A. Do you currently hold a certificate, registration or license to practice in the behavioral sciences in another state or jurisdiction? Yes \_\_\_ No \_\_\_

If "yes", please answer the following questions:

1. Under what name: \_\_\_\_\_
2. For which state \_\_\_\_\_ License Number: \_\_\_\_\_
3. For which credential: \_\_\_\_\_ Is this a clinical level? Yes \_\_\_ No \_\_\_
4. Does this credential allow you to practice independently, including the diagnosis and treatment of mental disorders? Yes \_\_\_ No \_\_\_
5. Date Issued: \_\_\_\_\_ Expiration Date \_\_\_\_\_
6. Was this continuous licensure? Yes \_\_\_ No \_\_\_  
If no, what period of time where you **NOT** licensed? \_\_\_\_\_

B. Have you ever filed any application for licensure or registration in Kansas? Yes \_\_\_ No \_\_\_

If "yes", please answer the following questions:

1. Under what name: \_\_\_\_\_
2. When: \_\_\_\_\_ For which credential: \_\_\_\_\_

**If you currently hold, or have ever held a certificate, registration, or license to practice in one of the behavioral or health sciences in another state or jurisdiction, you will need to have the former state Board(s) complete an Out-of-State Clearance Form. The state board should send the completed form directly to us.**

**IV. Merit of the Public Trust:**

A. Please answer the following questions. **Note: If the answer to any of the items 1 through 9 in this section is "Yes", submit as part of your application a signed, dated type-written explanation that gives specific details including disposition of the matter.**

1. Have you ever been charged with or convicted of a felony or misdemeanor other than a traffic violation? Yes \_\_\_ No \_\_\_
2. 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 \_\_\_
3. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds? Yes \_\_\_ No \_\_\_
4. Have you used any alcohol, narcotic, barbiturate 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 \_\_\_
5. 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 \_\_\_
6. 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 \_\_\_
7. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes \_\_\_ No \_\_\_
8. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit? Yes \_\_\_ No \_\_\_
9. 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 \_\_\_

**V. Educational Qualifications:**

A. **Transcript(s):** As part of the application process, each applicant is required to provide a verification of their degree. This can be verified by your state licensing agency on the out of state clearance form they are required to complete and submit. If your state licensing agency does not provide verification of your degree than you will be required to submit an official transcript from the Registrar's office of the college or university where your degree was granted. Please direct the school to send the transcript directly to the Board office. We will not accept transcripts sent directly from the applicant.

B. List all colleges or universities you have attended and at what level:

INSTITUTION	DATES OF ATTENDANCE From - To	MAJOR/AREA OF CONCENTRATION	DEGREE RECEIVED	DATE DEGREE CONFERRED

C. Give other name(s) under which your coursework was taken or your degree was conferred, if different from the name you use now:

*If you are using passage of an approved examination to meet clinical licensure requirements OR if you are required to submit passage of an approved examination, please complete the following:*

**VI. Examination:**

A. Did you complete the national Examination for your profession? Yes \_\_\_ No \_\_\_  
If you answered "yes" please answer the following:

- Name of examination \_\_\_\_\_ Who Administers the examination? \_\_\_\_\_
- What level of examination did you complete ? \_\_\_\_\_
- Through what state or jurisdiction \_\_\_\_\_ Date exam was taken \_\_\_\_\_
- Did you pass in your jurisdiction ? \_\_\_\_\_ Score Received \_\_\_\_\_

(Be sure to request verification of your passing score on Attachment A, or scores may be sent to the BSRB office directly from the examination service).

**VII. 15 Graduate Hours for Clinical Licensure**

If you are applying for a clinical, independent level of license and are using the 15 hours of graduate academic hours, please list here: Be sure to include a transcript, if one has not already been sent to the board office. (LSCSW exempt)

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**VIII. Applicant's Attestation:**

- I have reviewed the licensure eligibility requirements prior to submitting this application. Yes \_\_\_ No \_\_\_
- I have completed the application materials and procedures honestly and in good faith. Yes \_\_\_ No \_\_\_
- 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 \_\_\_
- 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 \_\_\_
- 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 \_\_\_
- 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 \_\_\_
- 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**

***Attachment A - Out-of-State Clearance Form***

**Instructions:**

Section 1 is to be completed by the applicant and then sent to the out-of-state board for completion. 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 the out-of-state board, and then returned directly to the board office.

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

- A. Name: \_\_\_\_\_
- B. Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
- C. Maiden or other name in which license was issued: \_\_\_\_\_
- D. Type of Credential held in the other state \_\_\_\_\_
- E. Type or Field of Practice: \_\_\_\_\_
- F. License Number: \_\_\_\_\_
- G. Date of Issuance: \_\_\_\_\_
- H. Date of Expiration: \_\_\_\_\_
- I. Level of Licensure (Baccalaureate, Masters, Doctorate): \_\_\_\_\_
- J. Current licensing requirements to be submitted with out of state clearance form ? **Yes** \_\_\_\_ **No** \_\_\_\_  
*If you are applying for licensure through "substantially equivalent" licensing requirements, your current licensing agency will need to provide current licensing requirements with this form.*

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

- A. Type of Credential (please circle applicable designation): Licensure \_\_\_\_ Registration \_\_\_\_ Certification \_\_\_\_
- B. Type or Field of Practice: \_\_\_\_\_
- C. Lic/Reg/Cert Title \_\_\_\_\_ Lic/Reg/Cert Number: \_\_\_\_\_
- D. Date Issued: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_
- E. Did license ever lapse or expire prior to date of expiration listed in letter "D"? **Yes** \_\_\_\_ **No** \_\_\_\_  
If yes, please explain \_\_\_\_\_
- F. Level of Lic/Reg/Cert (Baccalaureate, Masters, Doctorate): \_\_\_\_\_
- G. Does this license allow independent practice including the diagnosis and treatment of mental disorders?  
**Yes** \_\_\_\_ **No** \_\_\_\_
- H. Is Lic/Reg/Cert in Good Standing? **Yes** \_\_\_\_ **No** \_\_\_\_ If "no", please state reason(s):  
\_\_\_\_\_  
\_\_\_\_\_

I. Has the Lic/Reg/Cert ever been suspended or revoked? **Yes** \_\_\_ **No** \_\_\_ If **“yes”**, please state reason(s):

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

J. Has the Lic/Reg/Cert ever been surrendered voluntarily in lieu of an investigation? **Yes** \_\_\_ **No** \_\_\_  
If **“yes”**, please explain:

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

K. Degree Received \_\_\_\_\_ Major \_\_\_\_\_ Date Degree Received \_\_\_\_\_

L. University or Institution of where degree was completed \_\_\_\_\_

M. Current licensing requirements are attached with this clearance form? **Yes** \_\_\_ **No** \_\_\_

N. Examination Information:

Name of examination taken? \_\_\_\_\_

Who Administered the examination? \_\_\_\_\_

What level of examination did the licensee complete ? \_\_\_\_\_

Through what state or jurisdiction \_\_\_\_\_ Date exam was taken \_\_\_\_\_

Required score to pass ? \_\_\_\_\_ Score Received \_\_\_\_\_ 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: \_\_\_\_\_



**APPLICATION FOR LICENSURE THROUGH RECIPROCITY  
Attachment B - ATTESTATION FROM EMPLOYMENT SUPERVISOR or SELF**

**A. Instructions for Applicant:** Please complete the following information:

Applicant Name \_\_\_\_\_

Lic/Reg/Cert Type \_\_\_\_\_ Lic/Reg/Cert # \_\_\_\_\_

Place of Employment \_\_\_\_\_

Address of Employer \_\_\_\_\_  
Street City State Zip

Position/Title \_\_\_\_\_

Did you work at least 15 hours per week for 9 months during each of the 5 years? Yes \_\_\_\_ No \_\_\_\_  
 If **no**, how many hours worked, per week for how many years? \_\_\_\_\_

**If you have practiced independently skip Section II and complete Section III**

**II. Instructions for Supervisor:** Please complete the form and return to 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 \_\_\_\_\_ Lic/Reg/Cert \_\_\_\_\_

Employee's Work Dates \_\_\_\_\_  
Start Date End Date

Did applicant work at least 15 hours per week for 9 months during each year of the 5 years? Yes \_\_\_\_ No \_\_\_\_  
 If **no**, how many hours worked, per week for how many years ? \_\_\_\_\_

Does the applicant have at least 3 years of clinical practice that included diagnosis and 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: \_\_\_\_\_  
*Please describe type of work applicant was completing in this work setting*

Name of Supervisor \_\_\_\_\_ Lic/Reg/Cert Type and 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 \_\_\_\_\_

**Please place this form in a sealed envelope, sign across the closed seal and return to the applicant.**



**III. Independent Practice:** If you have been working in an independent practice setting, please complete the following:  
If you have not been working in an independent setting, please skip to section IV.

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 that included diagnosis and treatment of mental disorders.

Please attach one of the following forms of documentation with this form before submitting to the Kansas BSRB:

- 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.
- 

**IV. Signature**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_



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

**Instructions to Applicant:** Please have qualified individual complete form and return to you. At the time of application, submit this attestation to BSRB in a signed, sealed envelope. (This form is not to be used for LCSW applicants.)

**If you have practiced independently** please use this form to submit an attestation from one professional individual licensed to diagnose and treat mental disorders in independent practice or licensed to practice medicine and surgery that the applicant is competent to diagnose and treat mental disorders. Qualifying professionals include licensed psychologists, licensed clinical psychotherapists, licensed clinical professional counselors, licensed clinical marriage and family therapists, licensed specialist clinical social workers, and licensed physicians.

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

Name of Referencing Individual (please print) \_\_\_\_\_

Degree and Title: \_\_\_\_\_

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

The above named individual has applied for licensure in the state of Kansas. The Behavioral Sciences Regulatory Board is asking that you provide a written response attesting to this individual's competency to diagnose and treat mental disorders. Please complete all information requested and return to the applicant in a sealed envelope that has been signed across the seal.

- a) Are you related by blood or marriage to the applicant? Yes \_\_\_ No \_\_\_  
 If yes, state relationship: \_\_\_\_\_
- b) How long have you known the applicant? (please include dates) \_\_\_\_\_
- c) In what work setting have you known the applicant (Name of Agency) \_\_\_\_\_
- d) What relationship (such as supervisor, co-worker) have you had with the applicant which has aided you in forming any opinion of his/her competence? \_\_\_\_\_
- e) 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 mental health professional? Yes \_\_\_ No \_\_\_  
 If yes, please state these facts as fully as possible on a separate sheet of paper.
- f) In your opinion is the applicant competent to diagnose and treat mental disorders? Yes \_\_\_ No \_\_\_
- g) What evidence can you provide related to the applicant's competence to diagnose and 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.

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Current Position & Title

\_\_\_\_\_  
 Agency Name and Address

\_\_\_\_\_  
 Telephone #, Including Area Code

\_\_\_\_\_  
 City, State and Zip Code

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

**Sam Brownback**  
Governor

**Max L. Foster, Jr.**  
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## Credit Card Payment Form

**Only complete when paying by credit card.**

*The credit cards accepted are American Express, Discover, MasterCard and Visa.*

Amount of Purchase: \$ \_\_\_\_\_

Credit Card: American Express \_\_\_\_\_ Discover \_\_\_\_\_  
MasterCard \_\_\_\_\_ Visa \_\_\_\_\_

Credit Card Acct. # \_\_\_\_\_

Credit Card Expiration Date \_\_\_\_ / \_\_\_\_

Name as it appears on the card \_\_\_\_\_

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

**For Office Use Only:**

**Approval Number** \_\_\_\_\_ **Date** \_\_\_\_\_