Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
Max L. Foster, Jr., Executive Director

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov
Laura Kelly, Governor

APPLICATION FOR RENEWAL OF LICENSURE

Last Name: _____ First Name: _____ Middle: _____

License Level: _____ License # _____ Expiration Date ____/____/____ SS # _____-____-_____ DOB ____/_____/_____

Ethnic Information: African American _____ Native American _____ Asian Indian _____ Asian-Other _____ Hispanic _____
(optional)
Pacific Islander _____ White – Non Hispanic _____ Other, please specify _____

Languages that you speak: English _____ Spanish _____ Sign _____ Other, please specify:_____
(optional)

Preferred mailing address? Home _____Business _____ **Preferred E-mail address:** _____

Home Address: _____ Apt #: _____

City: _____State: _____ Zip: _____ - _____ County: _____

Phone #: ( ) _____ Cell phone #: ( ) _____

Business Name / Agency _____

Address Street: _____ Suite #: _____

City: _____State: _____ Zip: _____ - _____ County: _____

Phone #: ( ) _____ Fax #: ( ) _____

Do you work in Kansas: _____ If yes - Total number of hours you work per week in Kansas: _____ Work Setting**: _____
(optional)
**** see attached sheet for work setting codes/ numbers**

Other - specify: _____ Patients seen per week: _____ Hours per week at this site: _____
(optional)

Weeks per year at this site: _____ Percentage of hours providing care: _____ Another worksite in Kansas: _____
(optional)
If yes please attach additional sheet

Address of Record: _____ Suite #:_____

City: _____State: _____ Zip: _____ - _____ County: _____

Phone # ( ) _____ Fax # ( ) _____

Section I: **Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP)**

Are you willing to be included on a registry of potential volunteers to provide your professional services during an emergency?
Please check all that apply.

Within your county of residence: _____ Within 75 miles of your residence: _____

Anywhere in the State of Kansas: _____ Outside of the State of Kansas: _____

Section II: **PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS**

****If you answer "Yes" to any of the following six questions please include details on a separate sheet and submit with your renewal application. If you have had a complaint in Kansas please include the case number (if known).**

1. Since your last renewal, has your license in Kansas or any other state been limited, restricted, suspended, revoked or subjected to disciplinary action? Yes _____ No _____

2. Since your last renewal, have you been convicted of a felony and/or misdemeanor crime against person(s)?
Yes _____ No _____

3. Have you been placed on a child abuse registry or an adult protective services registry as the result of a substantiated finding of abuse or neglect? Yes _____ No _____

4. Since your last renewal, has a complaint or lawsuit been filed against you for unethical behavior, unprofessional conduct, or incompetence? Yes _____ No _____

5. Since your last renewal, has your employment been terminated or suspended for any form of misfeasance, malfeasance, or nonfeasance? Yes _____ No _____

6. In the past 24 months have you suffered from any impairment, which might affect your ability to safely practice?
Yes _____ No _____

If you hold a clinical/Independent license skip to section IV.

Section III: EMPLOYMENT INFORMATION

1. Are you working in a position that requires you to hold a BSRB License? Yes _____ No _____

2. Do you engage in the practice of addiction counseling outside of a state-licensed or certified alcohol and other drug treatment program or a program which is exempt for licensure under subsection (m) of K.S.A. 59-29B46?
Yes _____ No _____

3. Are you currently working under a clinical supervisory training plan? Yes _____ No _____
If yes, please state name, license type, and number of individual providing supervision and skip to section IV.

Name _____Type _____ Lic# _____

Section IV: PLEASE READ AND ATTEST TO THE FOLLOWING STATEMENT:

1. I understand that all CEU's being used for this renewal must be completed prior to my renewal application being submitted to the Board. Yes _____ No _____

2. I understand that I must have proof of all CEU's being used for this renewal prior to my renewal being submitted to the Board.
Yes _____ No _____

3. I further understand that failure to comply with statements one and two of this section will constitute unprofessional conduct and may result in disciplinary action against my license. Yes _____ No _____

4. I have read and agree to abide by the statutes, rules, and regulations governing the practice, for the professional license that I am renewing. Yes _____ No _____

RENEWAL APPLICANT PLEASE READ CAREFULLY BEFORE SIGNING

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

Signature_____ dated this _____day of_____, 20_____

Checklist: Please enclose the following:

Renewal Application
Continuing Education Reporting Form
Check, Money Order or completed credit card form

LAC $50.00
LMAC $75.00
LCAC $100.00

Renewals will not be processed prior to 90 days of expiration date.

Revised 3/8/2019

** Work Setting Codes

1. Administrative/regulatory agency
2. Ambulance company
3. Ambulatory surgery center
4. Assisted living facility
5. Business/Industrial establishment
6. Emergency room
7. Federal hospital or facility
8. Federally qualified health center
9. Free standing clinic
10. General hospital
11. HMO/Insurance Company
12. Home health agency
13. Hospital (Physician provides mainly inpatient services)
14. Independent laboratory
15. Independent living center
16. Indian Health Center
17. Individual practitioner
18. Local health department
19. Nursing/Long Term Care Facility
20. Partnership/group practice office
21. Pharmacy
22. Radiology/Imaging Center
23. Rehabilitation Hospital
24. Rural health clinic
25. School district or educational cooperative
26. School clinic service environment
27. State or community mental retardation facility
28. State or community mental health facility
29. State governmental agency
30. Teaching Hospital
31. University or College
32. Community Mental Health Center
33. Foster Home Care Agency
34. Group Home Facility
35. Private Psychiatric Hospital
36. Public School System
37. Residential Treatment Facility for Emotionally Disturbed Children
38. Residential Treatment Facility for Mentally Retarded Children
39. Youth Detention Facility
40. Adult Detention, Jail or Prison
41. Other (specify)_____

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Addiction Counselor
Continuing Education Reporting Form

Licensee Name: _____ **License number:** _____

The information below is a general guideline. Please refer to K.A.R. 102-7-9 for further details.

		Total Hours
Seminar, Institute, Workshop, Course or Minicourse	*30 hrs Max*	
Academic Course – 1 Academic hour equals 15 CEUs	*30 hrs Max*	
Academic Course Audited - 1 Academic hour equals 15 CEUs	30 *hrs Max*	
Computerized interactive learning, telecast, videotape, audiotape or reading **WITH** A Post Test	*30 hrs Max*	
Computerized interactive learning, telecast, videotape, audiotape or reading With**OUT** A Post Test	5 *hrs Max*	
Cross Disciplinary Offerings (medicine, law, behavioral sciences, foreign / sign language, computer science, professional or tech. Writing skills, business or mgmt sciences)	*10 hrs Max*	
Self Directed Learning Project **Pre-**approved by the Board	*10 hrs Max*	
Supervision of Students	*10 hrs Max*	
First Time Preparation and Presentations	*10 hrs Max*	
First Time Publications	*10 hrs Max*	
Participation in Professional Organizations	*10 hrs Max*	
Did you complete a minimum of 3 hours of Ethics during this renewal cycle? **Yes** **No** Please circle		
Did you complete a minimum of 6 hours of Diagnosis and Treatment of substance use disorders during this renewal cycle? (LMAC & LCAC only) **Yes** **No** Please circle		

30 hours is required for each renewal cycle.	**TOTAL HOURS CLAIMED**	

I understand that in signing this document, I am attesting that I have completed the requisite minimum number of continuing education hours as of the date on this form, and that I possess the necessary documentation. I also understand that upon request of an audit I will be asked for such documentation. I further understand that upon proof of fraud, deceit, or any other act of unprofessional conduct in relation to my licensure renewal application, the Board may suspend, limit, revoke or refuse to renew my license.

Signature: _____ **Date**: _____

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Credit Card Payment Form

Complete only 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 _____**