

**Temporary Permit Application  
For Out-Of-State Independent/Clinical Addiction Counselors**

***Instructions***

**Applications should be submitted at least one week prior to the date needed.**

This application should be used by Out-Of-State Licensed Addiction Counselors, whose license allows for the *independent clinical practice of addiction counseling*, who wish to provide services in the State of Kansas or for the residents of Kansas, for a limited amount of time.

Please read all instructions and review the statutes and regulations, before beginning to complete the application. The statutes and regulations can be found on our website, [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov).

- 1. Application:** Please answer all questions on the application completely and accurately.
- 2. Fee:** The \$200.00 application fee must accompany your application. Make checks or money orders payable to "Behavioral Sciences Regulatory Board" or "BSRB". Credit cards are also accepted. **ALL FEES ARE NON-REFUNDABLE.**
- 3. Verification:** The Board office will attempt to verify your license(s) on-line. If this service is not available on your state licensing board's website you will need to request a verification of your license(s) be sent directly to the BSRB office. **You must have an active license that is in good standing in order to be eligible for this temporary permit.**
- 4. Review:** It is extremely important for you to understand that the Board cannot determine whether you are eligible for the temporary permit until all of the application materials have been received and approved by the Board office. Please allow one week for your application to be reviewed.
- 5. Temporary Permit:** If approved, your temporary permit will be effective on the date of approval by the Board and shall expire on December 31 of that year. This temporary permit allows you to engage in the independent practice of clinical addiction counseling for a maximum of 15 days. Any clinical addiction counseling services rendered within any 24-hour period shall count as one entire day of clinical addiction counseling services.
- 6. Extension of Temporary Permit:** If necessary, your temporary permit may be extended for an additional 15 days within the calendar year. This request must be made in writing and should be accompanied by the \$200.00 extension fee. *This would not affect your eligibility for a temporary permit in the following calendar year.*

**Please submit your signed application with the application fee to:**

**Behavioral Sciences Regulatory Board  
700 S.W. Harrison St., Ste. 420  
Topeka, KS 66603**

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



Phone: 785-296-3240  
Fax: 785-296-3112  
[www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov)  
Laura Kelly, Governor

## *Temporary Permit Application For Out-Of-State Independent/Clinical Addiction Counselors*

**Application Fee: \$200.00 check, money order, or credit card payable to BSRB**

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

**II. Please provide the following information: (If you hold more than one license, please attach an additional sheet for all other licenses with answers to questions A-F for each one.)**

**A. Type of license you currently hold:** \_\_\_\_\_

**B. License number:** \_\_\_\_\_ **Issue Date:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**C. Is this an independent clinical level of licensure? Yes \_\_\_\_\_ No \_\_\_\_\_**

**D. State from which above listed license was issued:** \_\_\_\_\_

- Does the above listed state provide the service of on-line license verification at no cost? **Yes**\_\_\_\_\_ **No**\_\_\_\_\_
- **If “No”** you will need to have your state board send verification of your license(s) directly to the board office.

E. Is this license in good standing? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

F. Please list the person or agency that has requested your services in Kansas: \_\_\_\_\_  
\_\_\_\_\_

G. What services will you be providing in Kansas or for Kansas residents? \_\_\_\_\_  
\_\_\_\_\_

H. How long do you plan to provide the above stated services? \_\_\_\_\_  
▪ Start date Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_  
▪ End date Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

I. Please list the address to which you wish to have your temporary permit mailed (if different from preferred mailing address): \_\_\_\_\_  
\_\_\_\_\_

J. ***Please include a copy of your current license(s) with this application.***

K. I understand that if a temporary permit is issued to me by the State of Kansas I shall be deemed to have submitted to the jurisdiction of the board and shall be bound by the statutes and regulations that govern the practice of clinical addiction counseling in the State of Kansas. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**III. Applicant's attestation.**

I understand in signing this document I attest that, to the best of my knowledge, the information provided herein is true and correct. I further understand that it is unlawful to attempt to obtain licensure through fraudulent misrepresentation.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



## 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:**

Receipt Number \_\_\_\_\_ Date \_\_\_\_\_