



Behavioral Sciences Regulatory Board  
700 SW Harrison St. Suite 420  
Topeka, KS 66603-3929

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

David B. Fye, JD, Executive Director

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 \_\_\_\_\_ 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**

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

**\*\*If you answer "Yes" to any of the following five 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 or misdemeanor? 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 \_\_\_\_\_

**Section III: EMPLOYMENT INFORMATION**

- 1. Are you working in a position that requires you to hold a BSRB License? Yes \_\_\_\_\_ No \_\_\_\_\_
- 2. Are you currently working in a private practice without supervision? Yes \_\_\_\_\_ No \_\_\_\_\_

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

- 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# \_\_\_\_\_

- 4. Are you conducting psychotherapy in your current mental health position? Yes \_\_\_\_\_ No \_\_\_\_\_  
**If yes, please state name, license type and number of individual providing direction/supervision and skip to section IV.**

Name \_\_\_\_\_ Type \_\_\_\_\_ Lic# \_\_\_\_\_

- 5. **If you do NOT hold a clinical/independent license, please answer the following:**

Name of the individual providing your direction/supervision? \_\_\_\_\_

Supervisor's Position/Title \_\_\_\_\_ Agency \_\_\_\_\_

**Social Work - See Definitions K.A.R. 102-2-1a (cc) (1 & 2)**  
**Master Level Psychology - See Definitions K.A.R. 102-4-1a (x)**

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

- 1. I understand that, prior to my renewal application being submitted, all CEU's being used for this renewal must be completed or I must submit a **Request for Additional Time to Complete Continuing Education Hours** form and be approved for additional time to complete my CEUs. Yes \_\_\_\_\_ No \_\_\_\_\_

Note: Individuals seeking to renew their license who have not completed all CEUs due to extenuating circumstances may submit a **Request for Additional Time to Complete Continuing Education Hours** form to the BSRB, requesting additional time to complete those hours. If your request is granted, this will not extend your license, but will allow up to 3 months of additional time solely to complete remaining CEUs for that license period. Separately, you will still need to complete all CEUs for the new license period. **Request for Additional Time to Complete Continuing Education Hours** forms must be submitted no later than 30 days before the expiration of your license and must be approved before you can renew your license.

- 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 or I have submitted a **Request for Additional Time to Complete Continuing Education** Hours and have received specific approval from the BSRB for additional time to complete CEUs 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**  
**Please see Appendix A for payment instructions**

LMFT \$100.00  
LCMFT \$125.00

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

## **\*\* 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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## Marriage & Family Therapist Continuing Education Reporting Form

Licensee Name: \_\_\_\_\_ License number: \_\_\_\_\_

The information below is a general guideline. Please refer to K.A.R. 102-5-10 for further details.

	Total Hours
Workshop, Seminar, Institute, Course or Minicourse	40 hrs Max
Academic Course – 1 Academic hour equals 15 CEUs	40 hrs Max
Academic Course for Audit – 1 Academic hour equals 15 CEUs	40 hrs Max
Computerized interactive learning, telecast, video recording, audio recording or reading <b>WITH Post-test</b>	40 hrs Max
Computerized interactive learning, telecast, video recording, audio recording or reading With <b>OUT</b> Post-test	10 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 <b>Pre</b> approved by the board	10 hrs Max
Supervision of Students	15 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 during this renewal cycle?	Yes      No Please circle
If you are a board approved supervisor, did you complete at least 3 hours of Supervision CEUs including at least 1 hour of Ethics in Supervision?	Yes      No Please circle

<b>40 hours is required each renewal cycle.</b>	<b>TOTAL HOURS CLAIMED</b>	
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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 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 reinstate my license.

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

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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](http://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.