



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

Max L. Foster, Jr., 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 _____ 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 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. Since your last renewal, has a complaint or lawsuit been filed against you for unethical behavior, unprofessional conduct, or incompetence? Yes _____ No _____
4. Since your last renewal, has your employment been terminated or suspended for any form of misfeasance, malfeasance, or nonfeasance? Yes _____ No _____
5. In the past 24 months have you suffered from any impairment, which might affect your ability to safely practice? Yes _____ No _____

Section III: 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
\$150.00 Renewal fee paid by Check, Money Order or Credit Card**

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

**** Work Setting Codes**

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

Revised: 3/8/2019



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Psychology Continuing Education Reporting Form

Licensee Name: _____ License number: _____

Date of Original Licensure

Hours Required

On or before 12/31/18
 01/01/19 – 06/30/19
 07/01/19 – 12/31/19
 01/01/20 – 06/30/20

50 Hours *
 33 Hours *
 17 Hours *
 0 Hours

*** If you are required to complete continuing education during this renewal cycle, it must include three hours of ethics and six hours of diagnosis and treatment.**

The information below is a general guideline. Please refer to K.A.R. 102-1-15.

		Total Hours
Seminar, Workshop, Presentations	<i>50 hrs Max</i>	
First Time Preparation and Presentations	<i>15 hrs Max</i>	
Completion of a Self-Study Program	<i>12 hrs Max</i>	
Completion of a Self-Study Program WITH a POST TEST	<i>40 hrs Max</i>	
Publication and Professional Presentation (15 per each paper)	<i>45 hrs Max</i>	
Academic Psychology Course (1 Academic hour equals 15 CEUs)	<i>50 hrs Max</i>	
Providing Supervision	<i>15 hrs Max</i>	
Receiving Supervision	<i>15 hrs Max</i>	
Initial Preparation for Specialty Board Examination	<i>25 hrs Max</i>	
Participation in Quality Care Activities	<i>15 hrs Max</i>	
Participation in Professional Organizations	<i>12 hrs Max</i>	
Receiving Personal Psychotherapy	<i>20 hrs Max</i>	
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	

	TOTAL NUMBER OF HOURS CLAIMED	
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I understand that in signing this document, I am attesting that I have completed the requisite minimum number of psychology 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 relationship 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 _____