

Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
David B. Fye, JD, Executive Director



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 _____

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 _____

For additional information, please review the definition of "under direction" in your profession's definitions regulation.

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

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**

LASW \$50.00
LBSW \$50.00
LMSW \$75.00
LSCSW \$100.00

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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Social Work - Continuing Education Reporting Form

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

Please refer to K.A.R. 102-2-4a for continuing education requirements.

	Total Hours
Program, Seminar, Institute, Workshop,	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, videotape, audiotape or reading WITH A Post-test	40 hrs Max
Computerized interactive learning, telecast, videotape, audiotape or reading WithOUT A Post-test	10 hrs Max
Cross Disciplinary (medicine, law, behavioral sciences, foreign / sign language, computer science, professional or tech. writing skills, business or mgmt sciences or others if the offering is clearly related to the enhancement of social work)	10 hrs Max
Self Directed Learning Project approved by the board	10 hrs Max
Supervision of Students (shall not exceed 4 hours per semester)	16 hrs Max
Program by approved program provider	40 hrs Max
Single program approved provider	40 hrs Max
First Time Preparation and Presentations – 10 to prepare and up to 10 to present	20 hrs Max
First Time Publications	10 hrs Max
Participation in Professional Organizations	12 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? <i>(LBSW's are exempt from Diagnosis and Treatment CEU requirement)</i>	Yes No Please circle
Is this your first-time to renew your Social Work License at this level (LBSW, LMSW, LSCSW)	Yes No
If your answer is "Yes," please answer the following question.	Please circle
Have you ever completed six continuing education units of Social Worker Safety Awareness Training?	Yes No Please circle
40 hours are required every 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 _____

<p>For Office Use Only:</p> <p>Approval Number _____ Date _____</p>
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