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

Kansas
Behavioral Sciences
Regulatory Board

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

INSTRUCTIONS FOR LICENSURE APPLICATION THROUGH RECIPROCITY

1. Before you begin to complete the application form, please read all instructions and review the statutes and regulations so that you will understand exactly what information is being requested. The statutes and regulations can be found on our website, www.ksbsrb.ks.gov. **You must hold an active license in another state to apply for licensure through reciprocity.**

2. **Criminal Conviction/s -** You are required to report the following convictions:
A. Conviction of any felony
B. Conviction of any misdemeanor crime against a person

Either of the above listed convictions will require you to complete the Conviction Packet. You may click on this link to download the: Conviction Packet or you may find this packet on our website, www.ksbsrb.ks.gov under forms. You must return the required documentation with your application packet. ***Your application will not be reviewed without this information*.** Your application will require a determination from the full Board on eligibility for licensure. **Please allow extra time for a decision to be made on your application.**

3. **Email.** The BSRB requires you that you provide an email address. Email is the Board's primary method of communication. If you change your email address, update your information with the Board office right away.

4. Instructions for paying the $50.00 application fee may be found on **Appendix A**. FEES ARE NON-REFUNDABLE.

5. As part of the application process, you are required send the **License Verification form** to each of the licensing boards or jurisdictions you hold, or have held, a mental health professional license. The licensing agency should complete the form and return it directly to the board office.

6. Depending on your profession and which type of license you are applying for there are some differences in what is required for each license and even what level of license you are applying for. Please be sure to review the statutes and regulations for a detailed explanation.

7. **Masters Level Psychology (LMLP), Professional Counselors (LPC), Marriage and Family Therapy (LMFT)**
Option 1 – Requirements of licensure for your state are substantially equivalent to Kansas requirements for licensure. See K.S.A. 74-5375(a)(1) for Master's Level Psychology, See K.S.A. 65-5807 (a)(1) for Professional Counseling, K.S.A. 65-6406 (a)(1) for Marriage and Family Therapy.

Option 2- A – Registration, certification or licensure with a similar scope of practice for at least 12 months immediately preceding the date of application for reciprocity with Kansas.
B – Absence of disciplinary action of a serious nature brought by a registration, certification or licensing board. This will be attested to on Attachment A and should be completed by your licensing agency.
C – a master's degree in your profession from a regionally accredited university or college.

8. **Clinical Psychotherapist (LCP), Clinical Professional Counseling (LCPC), and Clinical Marriage and Family Therapy (LCMFT**)
In addition to the requirements listed in #6, after meeting option 1 or 2, you must also demonstrate the ability to diagnosis and treat mental disorders through at least two of the following areas acceptable to the board:
A. **1.** Passed a national clinical examination approved by the board. Complete Section VI of the application. **OR**
2. Satisfactory completion of 15 graduate credit hours supporting diagnosis or treatment of mental disorders;
- LCP's must demonstrate at least 3 of the 15 hours in a discrete course of psychopathology. The remaining 12 shall consist of diagnostic assessment, interdisciplinary referral and collaboration, treatment approaches and professional ethics. Complete Section VII of this application.
- LCPC's must demonstrate at least 2 of the 15 hours in a discrete psychopathology course and 2 discrete hours in a professional ethics course. The remaining 11 shall consist of diagnostic assessment, interdisciplinary referral and collaboration, treatment approaches and professional ethics. Complete Section VII of this application.
- LCMFT's must demonstrate at least 3 of the 15 hours in a discrete course of psychopathology. The remaining 12 shall consist of diagnostic assessment, interdisciplinary referral and collaboration, treatment approaches and professional ethics. Complete Section VII of this application.

B. An attestation by a supervisor or other designated representative of your employer that you have had at least 3 years of clinical practice, including at least 8 hours of client contact per week during 9 months or more of each year in a community health center or its affiliate, a state mental hospital, or another employment setting in which you engaged in clinical practice that included diagnosis or treatment of mental disorders – Use Attachment A;

C. An attestation that the applicant has demonstrated competence in diagnosis or treatment of mental disorders That is signed by a professional licensed to practice medicine and surgery, or by a professional licensed psychologist, a licensed specialist clinical social worker, or another professional licensed to diagnose and treat mental disorders in independent practice – Use Attachment B.

9. All Applicants:

Be sure your application for licensure through reciprocity that you are submitting to the board includes the following:

- application completed by the applicant;
- $50.00 application fee; see Appendix A;
- other forms of documentation required, depending on which route you are applying through (Attachment A, B, etc.).

The following items must be sent directly from the appropriate institution to the BSRB office:

- License Verification form submitted directly by your state or jurisdiction which you hold or have held a lic/reg/cert;
- exam score report (if not provided by your state of licensure) sent directly from the examination company;
- transcripts sent directly from the university or college to the board office to verify 15 hours of graduate academic hours for clinical levels of licensure.

Please allow 30 days for review of your complete application. You may now **check the status of your application on our website** www.ksbsrb.ks.gov, under *"Services/Application Status Check."*

The board office will contact you by email regarding the status of your application. Be sure the board office has current contact information on file for you. It is the applicant's responsibility to notify the Board in writing of any name or address or email address change that might occur during the application process. Please remember that we will contact you by email.

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LICENSURE APPLICATION THROUGH RECIPROCITY

Application Fee Required: $50 please see Appendix A

This application is only for applicants who have been previously licensed in another state and are applying under the reciprocity statute.

Please be sure to review the requirements for your profession, there are differences among the different professions which include different required documentation.

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:**_____

Address of Record: (**Note:** The address of record is not required. It is a separate address that will be kept on file to be given out when requested by the public through the Kansas Open Records Act. If you do not indicate an address of record, your preferred mailing address will be used.)

Street Address: _____

City: _____ **State:** _____ **Zip+4:**_____

A. Are you a military servicemember (a current member of any branch of the United States armed services, United States military reserves or national guard of any state, or a former member with an honorable discharge) Yes____ No____
(If yes, please provide a copy of your military ID, a copy of your DD-214, or other proof of military service.)

B. Are you a military spouse (the spouse of a military servicemember)? Yes____ No____
(If yes, please provide a copy of your military ID, DD-214, or other proof of military service.)

C. Have you established residency in the State of Kansas? Yes____ No____

D. If no, do you intend to establish residency in the State Kansas? Yes____ No____
If "Yes" please explain:

_____

II. Application for Licensure

A. Are you applying for the **independent, clinical level of licensure** which allows you to diagnosis and treat mental disorders without being under supervision? Yes ____ No ___

B. What profession are you applying for through reciprocity? _____

(Master's Level Psychology, Marriage and Family Therapy, Professional Counseling)

III. Information on Previous Licensure:

A. Do you currently hold a certificate, registration or license to practice in the behavioral sciences in another state or jurisdiction?

Yes ____ No ___

If "NO", you are not eligible to apply for licensure through reciprocity. Please contact the Board office for other options to obtain a license.

If "yes", please answer the following questions:

1. Under what name:_____
2. For which state _____ License Number: _____
3. For which credential:_____ Is this a clinical level? Yes ____ No____
4. Does this credential allow you to practice independently, including the diagnosis and treatment of mental disorders? Yes ____ No ___
5. Date Issued: _____ Expiration Date _____
6. Was this continuous licensure? Yes ____ No ____
   If no, what period of time where you **NOT** licensed?_____

B. Have you ever filed any application for licensure or registration in Kansas? Yes____ No____
If "yes", please answer the following questions:

1. Under what name:_____
2. When:_____For which credential:_____

If you currently hold, or have ever held a certificate, registration, or license to practice in one of the behavioral or health sciences in another state or jurisdiction, you will need to have the former state Board(s) complete an Out-of-State Clearance Form. The state board should send the completed form directly to us.

IV. Educational Qualifications:

A. Transcript(s): As part of the application process, each applicant is required to provide a verification of their degree. This can be verified by your state licensing agency on the out of state clearance form they are required to complete and submit. If your state licensing agency does not provide verification of your degree than you will be required to submit an official transcript from the Registrar's office of the college or university where your degree was granted. Please direct the school to send the transcript directly to the Board office. We will not accept transcripts sent directly from the applicant.

B. List all colleges or universities you have attended and at what level:

INSTITUTION	**DATES OF ATTENDANCE** From - To	**MAJOR**/AREA OF CONCENTRATION	**DEGREE RECEIVED**	**DATE DEGREE CONFERRED**

C. Give other name(s) under which your coursework was taken or your degree was conferred, if different from the name you use now:

_____

If you are using passage of an approved examination to meet clinical licensure requirements OR if you are required to submit passage of an approved examination, please complete the following:

V. Examination:

A. Did you complete the national Examination for your profession? Yes____No____

If you answered "yes" please answer the following:

1. Name of examination _____
2. What level of examination did you complete? _____
3. Through what state or jurisdiction _____ Year exam was taken _____
4. Did you pass in your jurisdiction? _____

(Be sure to request verification of your passing score on the license verification form, or scores may be sent to the BSRB office directly from the examination service).

VI. 15 Graduate Hours for Clinical Licensure

If you are applying for a clinical, independent level of license and are using the 15 hours of graduate academic hours, you must list the courses that meet this requirement here. Practicum/Internship courses cannot be used to meet the 15 hours of clinical coursework. Be sure to include a transcript, if one has not already been sent to the board office.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VII. Merit of the Public Trust:

A. If you answer yes to question 1 and/or 2, regarding convictions, you are required to complete the Conviction Packet. Click on this link to download Conviction Packet or you may find this packet on our website, www.ksbsrb.ks.gov under forms. See # 2 in the instructions.

1. Have you ever been convicted of a felony? Yes____ No___
2. Have you ever been convicted of a misdemeanor crime against a person? Yes____ No____

B. If you answer "Yes" to any of the following questions, ***you are required to submit as part of your application a signed, dated, type-written explanation that gives specific details including disposition of the matter.***
Your application will not be processed without this information.

3. Have you ever had a complaint filed with a professional association or a certifying, licensing, or registering body against you for alleged unethical behavior or unprofessional conduct?
   Yes____ No____
4. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds?
   Yes____ No____
5. Have you used any alcohol, narcotic, barbiturate or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years?
   Yes____ No___
4. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years?
   Yes____ No____

5. Have you used controlled substances which were obtained illegally, or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years?

   Yes____ No____

6. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership?

   Yes____ No____

7. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit?

   Yes____ No____

8. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital, or state institution for the mentally retarded, or (3) an adult?

   Yes____ No____

VIII. Applicant's Attestation:

A. I have reviewed the licensure eligibility requirements prior to submitting this application. Yes____No____

B. I have completed the application materials and procedures honestly and in good faith. Yes____No____

C. I understand that the members and staff of BSRB are compelled by law to uphold, implement and enforce the licensure statutes and regulations as written.

   Yes____No____

D. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but any such research will not personally identify the applicants or licensees, either directly or indirectly.

   Yes____No____

E. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a BSRB form required for licensure or licensure renewal.

   Yes____No____

F. I **have read** and am familiar with the appropriate statutes and regulations governing the practice of the professional license for which I am applying.

   Yes____No____

G.

H. I understand that **once the Board receives my application I am bound by, and will abide by, the statutes and regulations** governing the profession of the license for which I am applying.

   Yes____No____

Signature:_____Date:_____

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License Verification form

Instructions:
Section 1 is to be completed by the applicant and then sent to the out-of-state board for completion. Additional copies of this form may be made and used as needed by the applicant.
Section 2 is to be completed by a representative of the out-of-state board, and then returned directly to the board office.

I. SECTION 1: This section is to be completed by the applicant:

A. Name:_____

B. Social Security #:_____Date of Birth:_____

C. Maiden or other name in which license was issued: _____

D. Type of Credential held in the other state_____

E. Type or Field of Practice:_____

F. License Number:_____

G. Date of Issuance:_____

H. Date of Expiration:_____

I. Level of Licensure (Baccalaureate, Masters, Doctorate):_____

J. Current licensing requirements to be submitted with out of state clearance form ? **Yes** _____ **No** _____
If you are applying for licensure through "substantially equivalent" licensing requirements, your current licensing agency will need to provide current licensing requirements with this form.

II. SECTION 2: This section is to be completed by the State Board. Upon completion, please return this form to: BSRB, 700 S.W. Harrison St. Ste 420, Topeka, KS 66603-3929.

A. Type of Credential (please circle applicable designation): Licensure_____Registration_____Certification_____

B. Type or Field of Practice:_____

C. Lic/Reg/Cert Title _____ Lic/Reg/Cert Number:_____

D. Date Issued:_____Date of Expiration:_____

E. Did license ever lapse or expire prior to date of expiration listed in letter "D"? **Yes** ___ **No** ____

If yes, please explain _____

F. Level of Lic/Reg/Cert (Baccalaureate, Masters, Doctorate): _____

G. Does this license allow independent practice including the diagnosis and treatment of mental disorders?

Yes ___ **No** ____

H. Is Lic/Reg/Cert in Good Standing? **Yes**____**No**____ If **"no"**, please state reason(s):

_____

_____

I. Has the Lic/Reg/Cert ever been suspended or revoked? **Yes**____ **No**____ If **"yes",** please state reason(s):

_____

_____

J. Has the Lic/Reg/Cert ever been surrendered voluntarily in lieu of an investigation? **Yes**____ **No**____
If **"yes",** please explain:

_____

_____

K. Degree Information:

University or College where degree was granted _____

What Degree did the licensee receive _____ Major _____

Date Degree Received _____

L. Examination Information:

Name of examination taken _____

Who Administered the examination _____

What level of examination did the licensee complete _____

Through what state or jurisdiction _____ Date exam was taken _____

Required score to pass _____ Score Received _____ Passed? **Yes** __ **No** __

M. Additional Comments:

Signature of State Board Representative: _____ Date: _____

Printed Name:_____

Official Title/Position:_____

State or Jurisdiction: _____

Agency:_____

Mailing Address:_____

Phone Number:_____ Fax Number:_____

Email Address: _____

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Attachment A – Three Years of Clinical Practice

If you provided clinical services in an independent, private practice setting when you completed the three years of clinical experience, please complete Section A and attach appropriate documentation, as listed below and return the form with your application for licensure.

If you were an employee when you completed the three years of clinical experience, please skip section A and have your work supervisor complete section B. The supervisor should return the completed form to you in a sealed envelope with their signature across the seal. You will submit the form in the unopened, signed envelope with the rest of your application materials.

The three years of clinical practice must have occurred AFTER your clinical/independent level of license was issued. Hours prior to that cannot be used to meet this requirement.

Applicant Name _____

A. Independent Practice: If you worked in an independent practice setting, please complete the following:

Name of Agency _____ Phone _____

Address of Agency _____ City_____ State_____ Zip_____

I _____, attest that I have engaged in a minimum of 3 years of independent clinical practice which included diagnosis and treatment of mental disorders, with at least eight hours of direct client contact per week for at least nine months of each year.

Check which one of the following forms of documentation you are submitting with your application for licensure:

_____ Published job description,
_____ Description of your practice in a public information brochure,
_____ Description of services in an informed consent document, or
_____ A similar published statement demonstrating you have engaged in independent clinical practice for a minimum of 3 years **OR**
_____ An attestation signed by a professional licensed to practice medicine and surgery, or a licensed psychologist, a licensed specialist clinical social worker, or a professional licensed to diagnosis and treat mental disorders in independent practice that attests to you working in private practice.

Signature of Applicant _____ Date_____

Printed Name of Applicant _____

B. Instructions for Supervisor: Please complete section B and return to the applicant in a sealed envelope with your signature across the seal.

Name of Employer _____

Address of Employer _____
Street City State Zip

Employer Phone _____ Employer Email _____

Applicant's Position/Title _____

Applicant's Lic/Reg/Cert Type _____ Applicant's Work Dates _____
Start Date End Date

Continued

Does the applicant have at least 3 years of clinical practice that included diagnosis or treatment of mental disorders?
Yes ____ **No** ____

If yes, did the applicant conduct at least 8 hours of client contact per week for 9 months or more of each year?
Yes ____ **No** ____

If no, how many client contact hours completed per week, per year? _____

Work Description: _____

_____

_____

Supervisor's Lic/Reg/Cert: Type: _____ Number: _____

I have been personally acquainted with the applicant **for** _____ **years.**

I attest that the applicant _____**is** _____**is not** competent in diagnosis and treatment of mental disorders.

I attest that the foregoing information supplied by the applicant is true to the best of my knowledge I believe the applicant to be of good professional character and worthy of confidence.

Supervisor Signature _____ Date _____

Printed Name of Supervisor: _____

Please return this form to the application in a sealed envelope with your signature across the seal.

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APPLICATION FOR LICENSURE THROUGH RECIPROCITY
Attachment B - ATTESTATION FROM A LICENSED PROFESSIONAL

Instructions to Applicant: Please have qualified individual complete form and return to you. At the time of application, submit this attestation to BSRB **in a signed, sealed envelope.**

Use this form to submit an attestation from one professional individual licensed to diagnose and treat mental disorders in independent practice or licensed to practice medicine and surgery that the applicant is competent to diagnose and treat mental disorders. Qualifying professionals include licensed psychologists, licensed clinical psychotherapists, licensed clinical professional counselors, licensed clinical marriage and family therapists, licensed specialist clinical social workers, and licensed physicians.

Name of Applicant:_____Date:_____

Name of Referencing Individual (please print)_____

Degree and Title:_____

License Type _____ License Number _____ State_____

The above named individual has applied for licensure in the state of Kansas. The Behavioral Sciences Regulatory Board is asking that you provide a written response attesting to this individual's competency to diagnose and treat mental disorders. Please complete all information requested and return to the applicant in a sealed envelope that has been signed across the seal.

a) Are you related by blood or marriage to the applicant? Yes ____ No _____
If yes, state relationship:_____

b) How long have you known the applicant? (please include dates)_____

c) In what work setting have you known the applicant (Name of Agency) _____

d) What relationship (such as supervisor, co-worker) have you had with the applicant which has aided you in forming any opinion of his/her competence?_____

e) Are you aware of any significant facts concerning the applicant's background which would reflect unfavorably on the applicant's character and fitness to practice as a mental health professional? Yes ___ No ____
If yes, please state these facts as fully as possible on a separate sheet of paper.

f) In your opinion is the applicant competent to diagnose and treat mental disorders? Yes ___ No ___

g) What evidence can you provide related to the applicant's competence to diagnose and treat mental disorders? Include amount and length of experience. (Feel free to expand on a separate sheet of paper if needed).

_____

Reference's Attestation: I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining the applicant's competence to diagnose and treat mental disorders in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable.

_____ _____
Signature Date

_____ _____
Agency Name and Address City, State and Zip Code

_____ _____
Telephone #, Including Area Code Email Address

Please return form back to applicant in a sealed envelope with your signature across the seal.

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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
(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 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 payment to the BSRB office by mail using a check, cash, or a money order may send the payment with their application to the Behavioral Sciences Regulatory Board, 700 SW Harrison St., Ste. 420, Topeka, KS 66603.

Please submit payment upon mailing your application if you are using the online payment portal.