

Disciplinary Action—This information is required under Kansas law: KSA 65-3503(a)

If you answer yes to any misdemeanor/felony/disciplinary question(s) on the application the required documentation must be received by this agency, or your application will be considered incomplete and cannot be processed. If you have questions about the conviction or disciplinary action requirements, please contact Karen Torbert at KDADS.Licensure@ks.gov. Review the information for an explanation regarding the documentation that must be submitted if you answer “yes” to any of the following questions.

Have you ever been convicted of a felony? Yes _____ No _____

Have you ever been convicted of a Class A misdemeanor? Yes _____ No _____

Have you had a judgement of settlement in civil record? Yes _____ No _____

Do you have any pending criminal case against you for a felony or Class A misdemeanor offense? Yes _____ No _____

Do you presently have any physical or mental conditions or use of drugs or alcohol that could affect your ability to competently and safely practice as a Speech Language Pathologist or an Audiologist? Yes _____ No _____
(if yes, submit an explanatory letter and physician’s release)

Has disciplinary action ever been taken against a Speech Language Pathologist or Audiologist license, a professional or occupational health care license, a mental health care license or a social worker license held by you, whether issued by this state or another state or jurisdiction?

Yes _____ No _____

(if yes, please provide specific details and copies of all relevant documents.)

Have you ever had a Speech Language Pathologist or Audiologist license denied, revoked, limited, suspended, or publicly or privately censured by a licensing authority? Yes _____ No _____

(if yes, please provide specific details and copies of all relevant documents.)

Are you registered, certified, or licensed in any other profession? Yes _____ No _____

If Yes, please list:

Have you ever voluntarily surrendered any professional license while an investigation or discipline case was pending? Yes _____ No _____

Have you ever allowed any professional license to expire while an investigation or discipline was pending? Yes _____ No _____

Do you have any pending investigations or disciplinary cases against you or your license, certification, or registration by a professional licensing authority? Yes _____ No _____

NOTE: Pursuant to state regulations, the agency requires that you provide all reports and court documents related to the conviction. Materials should be submitted to Health Occupations Credentialing. Please note, any and all costs for obtaining such reports/documents are your responsibility. You are also invited to submit a letter and any other additional supporting information or documents to the agency explaining the circumstances surrounding the case, complete resolution of the issue (including final probation, community corrections or parole documents), and how/why this situation is not expected to occur again. The applicant shall have the burden of proving that the applicant has been rehabilitated and warrants the public trust.

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the agency to verify any information provided in this application and attachments. I understand that the application fee is non-refundable should I not meet licensure qualifications.

I declare under penalty of perjury under the laws of the State of Kansas that the information provided above is true and correct to the best of my knowledge.

Signature: _____

Executed on: _____
(date)

Submit application, fee and supporting documents to:

KDADS.Licensure@ks.gov
or by mail:

Health Occupations Credentialing
Kansas Department for Aging and Disability Services
503 S Kansas Ave, Suite 300 C
Topeka, KS 66603-3404

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
 SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION
 HEALTH OCCUPATIONS CREDENTIALING
 CREDIT CARD AUTHORIZATION FOR VISA OR MASTERCARD

NAME OF INDIVIDUAL: _____

Please Print

As payment of fees for:

| Certification CNA/CMA/HHA ONLY |
|---------------------------------------|
| Course # _____ |
| _____ Certified Nurse Aide |
| _____ Interstate |
| _____ Certified Home Health Aide |
| _____ Certified Medication Aide |
| _____ CMA Renewal |
| _____ Reschedule State Test |
| _____ Allied |
| Fee amount paid _____ |

| Licensing - SLP, Audiology, Diet, Admin, Operator | |
|--|--|
| Circle Type to Select | enter credential number if known or X if new |
| Temporary | |
| Initial/Full | _____ Speech Language Pathologist |
| Reciprocal | _____ Audiologist |
| Renewal | _____ Dietitian |
| Reinstatement | _____ Adult Care Home Administrator |
| | _____ Operator Registration |
| \$ | Fee amount paid _____ |

FACILITY USE ONLY

FACILITY NAME AND ID FOR CRC: _____

| Criminal Record Check - Facility Use Only |
|--|
| Number of names checked: _____ |
| \$10.00 per name _____ |
| Total Paid \$ _____ |

VISA OR MASTERCARD NUMBER: _____ EXPIRATION _____/____

 PRINTED NAME OF CARD HOLDER (REQUIRED)

 AUTHORIZED SIGNATURE (REQUIRED)

Credit Card company service fee of 3.04% will be added to the total

| FOR OFFICE USE ONLY: | | |
|----------------------|--------------------|---------------------|
| AMOUNT: _____ | SERVICE FEE: _____ | TOTAL CHARGED _____ |
| | | |