KANSAS DEPARTMENT FOR AGING & DISABILITY SERVICES

Application For

REINSTATEMENT OF KANSAS DIETITIAN LICENSE

A Kansas dietitian license may be reinstated upon meeting requirements of K.S.A. 65-5909 and K.A.R. 28-59- 5a. Please complete this application documenting at least 15 hours of continuing education, return it with completed information inventory, proof of your social security number, and appropriate reinstatement fee of $235.

License Number:_____ Social Security Number:_____

Name:_____
Last First Middle (Other name(s) used)

Address:_____

Work Phone: (____)_____ Home Phone (___)_____

Record program approval number if program was prior approved, program title, date, and total clock hours per program in the appropriate column. Submit verification of attendance for all prior approved programs listed.

KDADS Approval Number *ONLY required if program was prior approved.*	Program Title	Program Date	Clock Hrs

(Use additional paper if needed)

(Please complete the remainder of the application on the back of this page)

LICENSE IN ANOTHER STATE

List all states in which you have ever held a dietitian license:

State:_____ State:_____ State:_____
State: _____ State: _____ State: _____

For each state, attach the printout of the online verification or have the board send it directly to the provided mailing address or email it to KDADS.Licensure@ks.gov.

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 practice as a dietitian competently and safely? **Yes _____** **No _____**
(if yes, submit an explanatory letter and physician's release)

Has disciplinary action ever been taken against a dietetic 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 dietitian 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 candidate shall have the burden of proving that the candidate 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:
Health Occupations Credentialing
Kansas Department for Aging and Disability Services
503 S Kansas Ave, Suite 300C
Topeka, Kansas 66603-3404
Or Email: **KDADS.Licensure@ks.gov**

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

wj 9.22.22