REINSTATEMENT APPLICATION FOR OPERATOR REGISTRATION

Operator Registration may be reinstated by obtaining 30 CE hours and payment of the $130.00 renewal and reinstatement fee *IF THE REGISTRATION HAS NOT LAPSED FOR MORE THAN 24 MONTHS.*

If lapsed for more than 24 months the applicant shall submit evidence of successful completion of the operator course within the most recent 24-month period and pay the $130.00 renewal and reinstatement fee.

Registration #: _____________ Social Security Number ________________________

Name____Other Name Used__________________

Address______________________________________City________________State_______Zip____________

Phone: Work(_______)_________________________ Home(_______)______________________________

RECORD OF CONTINUING EDUCATION CLOCK HOURS

Clock hours submitted for the purpose of reinstatement shall be earned within the 24 months preceding the application for reinstatement.

For Prior Approved Programs: Record approval number, title, date and hours. Verification of attendance for all prior approved programs listed must be submitted. For programs not Prior Approved: Record title, date and hours below. Required documents include: 1) course content, 2) objectives, 3) time frame of educational activity and 4) verification of attendance.

Approval Number	Program Title	Date	Resident Care 10 hours minimum	Administration 15 hours minimum	Electives Maximum 5 hours

DISCIPLINARY/CONVICTION HISTORY (K.S.A. 39-980)

Has your registration, license, certification issued by Kansas or another state or entity been denied, refused for renewal, suspended, revoked or subjected to any disciplinary action, or have you received a finding of abuse, neglect or exploitation against a resident of an adult care home, or have you been convicted of a crime by any state or federal court in the Unites States?
( ) No ( ) Yes If yes, attach explanation.

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/attachments.

Signature____**Date**_____________________

Please return this application to: KDADS.Licensure@ks.gov or
Health Occupations Credentialing - 503 S Kansas, 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 ________

wj 9.22.22