

**KATHLEEN SEBELIUS**  
Governor

**PHYLLIS GILMORE**  
Executive Director



712 S. Kansas Ave.  
Topeka, Kansas 66603-3817  
(785) 296-3240  
FAX (785) 296-3112  
[www.ksbsrb.org](http://www.ksbsrb.org)

**BEHAVIORAL SCIENCES REGULATORY BOARD**  
**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**

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 or misdemeanor? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Since your last renewal, has a complaint or lawsuit been filed against you for unethical behavior, unprofessional conduct, or incompetence? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Since your last renewal, has your employment been terminated or suspended for any form of malfeasance, malfeasance, or nonfeasance? Yes \_\_\_\_\_ No \_\_\_\_\_
5. In the past 24 months have you suffered from any impairment, which might affect your ability to safely practice? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered "Yes" to any of the above questions please include details on a separate sheet and submit with your renewal application.

**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 \_\_\_\_\_

**Social Work - See Definitions K.A.R. 102-2-1a (cc) (1 & 2)**  
**Master Level Psychology - See Definitions K.A.R. 102-4-1a (x)**

**Section IV: PLEASE READ AND ATTEST TO THE FOLLOWING STATEMENT:**

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**

LP \$200.00	LCP \$175.00	LCPC \$175.00	LCMFT \$175.00	LSCSW \$150.00	RAODAC \$100.00
	LMLP \$150.00	LPC \$150.00	LMFT \$150.00	LMSW \$125.00	
				LBSW \$100.00	
				LASW \$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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**Professional Counselor**  
**Continuing Education Reporting Form**

**Licensee Name:** \_\_\_\_\_ **License number:** \_\_\_\_\_

**The information below is a general guideline. Please refer to K.A.R. 102-3-10a for further details.**

	<b>Total Hours</b>
Seminar, Institute, Workshop, Course or Minicourse	<i>30 hrs Max</i>
Academic Course – 1 Academic hour equals 15 CEUs	<i>30 hrs Max</i>
Academic Course Audited - 1 Academic hour equals 15 CEUs	<i>30 hrs Max</i>
Computerized interactive learning, telecast, videotape, audiotape or reading <b>WITH</b> A Post Test	<i>30 hrs Max</i>
Computerized interactive learning, telecast, videotape, audiotape or reading <b>WithOUT</b> A Post Test	<i>5 hrs Max</i>
Cross Disciplinary Offerings (medicine, law, behavioral sciences, foreign / sign language, computer science, professional or tech. Writing skills, business or mgmt sciences)	<i>10 hrs Max</i>
Self Directed Learning Project <b>Pre</b> approved by the Board	<i>10 hrs Max</i>
Supervision of Students	<i>10 hrs Max</i>
First Time Preparation and Presentations	<i>10 hrs Max</i>
First Time Publications	<i>10 hrs Max</i>
Participation in Professional Organizations	<i>10 hrs Max</i>
<b>Did you complete a minimum of 3 hours of Ethics during this renewal cycle?</b>	<b>Yes      No</b> Please circle
<b>Did you complete a minimum of 6 hours of Diagnosis and Treatment during this renewal cycle?</b>	<b>Yes      No</b> Please circle

**30 hours is required for each 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 \_\_\_\_\_

**For Office Use Only:**

**Approval Number** \_\_\_\_\_                      **Date** \_\_\_\_\_