

**SAM BROWNBACK**  
Governor

**TOM HAWK, Ph.D.**  
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

### INSTRUCTIONS FOR APPLICATION THROUGH RECIPROCITY FOR PSYCHOLOGY LICENSURE

Please read all instructions and review the statutes and regulations, before beginning to complete the application. The statutes and regulations may be found our website, [www.ksbsrb.org](http://www.ksbsrb.org).

**You must hold an active license in another state to apply for licensure through reciprocity.**

1. Please answer all questions on the application completely and accurately. If there have been any felony convictions or other events that potentially raise questions about your ability to merit the public trust, additional information will be requested.
2. The \$225.00 application fee must accompany your application. This fee should be made payable to "Behavioral Sciences Regulatory Board" or "BSRB" by check, money order, or credit card. **ALL FEES ARE NON-REFUNDABLE.**
3. As part of the application process, you are required to send **Attachment A = Out-Of-State Clearance form** to each of the licensing boards or jurisdictions you hold, or have held, a license, registration, or certification to practice psychology. The licensing agency should complete the form and return it directly to the board office.
5. When applying through reciprocity there are two possible routes that you may use.

#### **Route One:**

The standards of your state's requirements are substantially equivalent to Kansas requirements for licensure, registration or certification. See K.S.A. 74-5315. For licensure requirements see K.A.R. 102-1-5a and 102-1-12.

#### **Route Two:**

A – Continuous registration, certification or licensure to practice psychology at the doctoral level during the five years immediately preceding the date of application for reciprocity with Kansas with the minimum professional experience required by the board.

(i) Minimum professional experience is determined to be at least 15 hours of work experience per week for 9 months during each of the 5 years immediately preceding the date of application.

Submit an attestation which is Attachment B of this application with your application.

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 doctoral degree in psychology from a regionally accredited university or college.

**When you submit your application to the Board office the following items should be included:**

- The completed application form;
- The application fee of \$225.00 made payable to BSRB by check, money order, or credit card;
- If applying through route Two, Attachment B.

Please submit a complete application so that your application will not have to be returned.

**These additional items need to be sent directly to the Board office from the appropriate institutions:**

- An official transcript that shows the degree earned and the date the degree was conferred from your university;
- Attachment A - Out-of-State Clearance form, from each of the licensing boards or jurisdictions you hold, or have held, a license, registration, or certification to practice psychology.

Please allow 30 days for review of your application. You may now **check the status of your application on our website [www.ksbsrb.org](http://www.ksbsrb.org)**, under "Online Services."

*The board office will contact you by mail or 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 change that might occur during the application process.*

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**BEHAVIORAL SCIENCES REGULATORY BOARD**

**LICENSURE APPLICATION THROUGH RECIPROCITY**

**Application Fee Required: \$225.00 check, money order or credit card made payable to BSRB**

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

(Type or print in ink)

**I. Identifying information:**

A. Name: \_\_\_\_\_

B. If you have ever been known by any other name(s), please list: \_\_\_\_\_

C. Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Preferred Mailing Address: Home  Office

D. Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (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.)

E. Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ E Mail: \_\_\_\_\_

F. Employing Agency: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Office Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

G. 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 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip +4 \_\_\_\_\_

**II. Information on Current Licensure:**

A. Do you currently hold a certificate, registration or license to practice mental health in another state or jurisdiction? Yes \_\_\_ No \_\_\_

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.

**III. Merit of the Public Trust:**

A. Please answer the following questions. **Note: If the answer to any of the items 1 through 9 in this section is "Yes", submit as part of your application a signed, dated type-written explanation that gives specific details including disposition of the matter.**

1. Have you ever been charged with or convicted of a felony or misdemeanor other than a traffic violation? Yes\_\_\_\_No\_\_\_\_
2. 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\_\_\_\_
3. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds? Yes\_\_\_\_No\_\_\_\_
4. Have you used any alcohol, narcotic, barbiturate 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\_\_\_\_
5. 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\_\_\_\_
6. 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\_\_\_\_
7. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes\_\_\_\_No\_\_\_\_
8. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit? Yes\_\_\_\_No\_\_\_\_
9. 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\_\_\_\_

**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 completed the following:*

**VI. 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 \_\_\_\_\_ Who Administers the examination? \_\_\_\_\_
2. What level of examination did you complete ? \_\_\_\_\_
3. Through what state or jurisdiction \_\_\_\_\_ Date exam was taken \_\_\_\_\_
4. Did you pass in your jurisdiction ? \_\_\_\_\_ Score Received \_\_\_\_\_

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

**VII. 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, please list here: Be sure to include a transcript, if one has not already been sent to the board office. *(LSCSW exempt)*

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

**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 statutes and regulations governing the practice psychology in the State of Kansas. Yes \_\_\_ No \_\_\_
- G. 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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**APPLICATION FOR LICENSURE THROUGH RECIPROCIITY**

**Attachment A - Out-of-State Clearance 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, 712 S. Kansas Avenue, Topeka, KS 66603-3817.**

- 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 Received \_\_\_\_\_ Major \_\_\_\_\_ Date Degree Received \_\_\_\_\_

L. University or Institution of where degree was completed \_\_\_\_\_

M. Current licensing requirements are attached with this clearance form? **Yes** \_\_\_ **No** \_\_\_

N. 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** \_\_\_

N. 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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**APPLICATION FOR LICENSURE THROUGH RECIPROCITY**  
**Attachment B - ATTESTATION FROM EMPLOYMENT SUPERVISOR or SELF**

**A. Instructions for Applicant:** Please complete the following information:

Applicant Name \_\_\_\_\_

Lic/Reg/Cert Type \_\_\_\_\_ Lic/Reg/Cert # \_\_\_\_\_

Place of Employment \_\_\_\_\_

Address of Employer \_\_\_\_\_

Position/Title \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Dates Worked at This Site \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Did you work at least 15 hours per week for 9 months during each of the 5 years? Yes \_\_\_\_\_ No \_\_\_\_\_

If **no**, how many hours worked, per week for how many years? \_\_\_\_\_

**If you have practiced independently skip Section II and complete Section III**

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

Name of Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Phone \_\_\_\_\_ Employer Fax \_\_\_\_\_

Applicant's Position/Title \_\_\_\_\_ Lic/Reg/Cert \_\_\_\_\_

Employee's Work Dates \_\_\_\_\_  
Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Did applicant work at least 15 hours per week for 9 months during each year of the 5 years? Yes \_\_\_\_\_ No \_\_\_\_\_

If **no**, how many hours worked, per week for how many years? \_\_\_\_\_

Does the applicant have at least 3 years of clinical practice that included diagnosis and 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: \_\_\_\_\_  
*Please describe type of work applicant was completing in this work setting*

Name of Supervisor \_\_\_\_\_ Lic/Reg/Cert Type and 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 \_\_\_\_\_

**Please place this form in a sealed envelope, sign across the closed seal and return to the applicant.**

**III. Independent Practice:** If you have been working in an independent practice setting, please complete the following:  
If you have not been working in an independent setting please skip to section IV.

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 that included diagnosis and treatment of mental disorders.

Please attach one of the following forms of documentation with this form before submitting to the Kansas BSRB:

- 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.

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**IV. Signature**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_