



11. Has **any** license, certification or registration (nursing or other) ever been denied, revoked, suspended, limited or disciplinary action taken by a licensing authority of any state, agency of the US government, territory of the US or country? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, where: \_\_\_\_\_  
 (If answer is yes, please attach certified/dated copy of board order and/or governmental agency disciplinary action and explanatory letter. Note if previously submitted to KSBN and give KSBN case number. Do not send a second copy)

12. List other states, territories or countries in which you have been licensed and the type of Nursing license you held (RN, LPN, ARNP): **(If additional pages needed, sign and date each attached page)**

\_\_\_\_ Not applicable

State/Type	License #	Year of Issue	State/Type	License #	Year of Issue
State/Type	License #	Year of Issue	State/Type	License #	Year of Issue

13. Please select one:

\_\_\_\_\_ **Inactive**

If you wish to have your license placed on "Inactive" status, please place a check mark next to "INACTIVE". Complete questions 1 – 12, sign and date this application and return with the appropriate fee. Continuing education hours are not required for "Inactive" Status.

\_\_\_\_\_ **Exempt (Must complete page 3)**

If you wish to have an exempt license (not regularly engaged in nursing practice in Kansas, but volunteer nursing service or are a charitable health care provider as defined by K.S.A. 75-6102), place a check mark next to "Exempt". Continuing education hours are not required for "Exempt" status. A copy of your contract with KDHE is required to establish your status as a charitable health care provider.

\_\_\_\_\_ **First Renewal Following Examination**

If you passed the NCLEX examination **less than 30 months prior to the expiration of your license**, place a check mark next to "First Renewal". Continuing education hours are not required for "First Renewal" status.

\_\_\_\_\_ **Endorsement or Reinstatement less than 9 months prior to license expiration**

If you received your license in Kansas through endorsement or reinstatement less than 9 months prior to the license expiration date, place a check mark next to "Endorsement or Reinstatement". Continuing education hours are not required for "Endorsement/Reinstatement" status. If you have questions about whether you need CE or the date of issue of your license, please contact KSBN.

\_\_\_\_\_ **Renewal – List Continuing Nursing Education Below**

Mandatory Continuing Nursing Education: List at least 30 contact hours of continuing education approved by a state board of nursing or national nursing organization/association. CE that has not been approved for nursing must be submitted prior to renewal using the Individual Offering Approval form. If selected for an audit of CE hours, notification will be received by mail and you will be given 21 days to submit copies of CE to the Board office. DO NOT mail copies of CE certificates with your renewal.

Title of Workshop or College Course	Name of Approved Provider/ College/University and Provider Number or Nursing Degree pursuing if applicable	Date Completed (MM/DD/YYYY)	Hours (Minimum 1 Contact Hr)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If additional space is needed attach a separate page and **sign and date the attachment** Total Hours \_\_\_\_\_

14. Are you: \_\_\_\_\_ Employed as a nurse? \_\_\_\_\_ Hospital \_\_\_\_\_ Long term care \_\_\_\_\_ Office/Clinic  
 (if yes, indicate setting) \_\_\_\_\_ Community/Home Health \_\_\_\_\_ Other Nursing  
 \_\_\_\_\_ Employed, not as a nurse  
 \_\_\_\_\_ Not Employed  
 \_\_\_\_\_ Retired

Interested in volunteering your skills in a disaster or other emergency? Register on K-SERV, a new data base designed to improve volunteer management during disasters. Go to <https://kshealth.kdhe.state.ks.us> and select "login or register for K-SERV."

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**  
 (DO NOT WRITE BELOW (FOR OFFICE USE ONLY))

\_\_\_\_\_  
**Date (MM/DD/YYYY)**

**COMPLETE ONLY IF YOU ARE APPLYING FOR EXEMPT STATUS**

**Exempt Status: (You must answer yes to one of the following)**

A. Are you providing or do you intend to provide volunteer nursing or mental health technology services?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, provide the following information for each business, organization or individual for whom you will volunteer:

_____	_____	_____	_____
Name	Address	Contact Name	Contact phone number
_____	_____	_____	_____
Name	Address	Contact Name	Contact phone number
_____	_____	_____	_____
Name	Address	Contact Name	Contact phone number

B. Are you a charitable health care provider as defined by K.S.A. 75-6102? Yes \_\_\_ No \_\_\_

**If you are a charitable health care provider, attach a copy of your agreement with the Secretary of Kansas Department of Health and Environment acknowledging your status as a charitable health care provider under K.S.A. 75-6102 and amendments thereof.**

Please provide name, address and phone number where you are providing charitable health care:

_____	_____	_____	_____
Name	Address	Contact Name	Contact phone number

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.

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\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date (MM/DD/YYYY)**

## INSTRUCTIONS FOR COMPLETION OF RENEWAL APPLICATION

***Online Renewal is available!!!***

***www.ksbn.org***

### To renew online:

- You must have access to the Internet, a checking account or credit card, and your PIN (located on your renewal notice).
- Log onto [www.ksbn.org](http://www.ksbn.org).
- Choose Online License Renewals and follow the directions on the screen.
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***There is no need to mail a renewal application to the Board of Nursing when using Online Renewal.***

There are some cases where individuals are not eligible to use the online license renewal process at this time. Do not proceed online if:

- Initiating or renewing inactive license status
- Renewing an exempt license
- If your license has been disciplined, under investigation, or you have had other legal issues, the system will not allow you to renew your license online.
- If you have more than one license and you would like to renew only one.

### To Renew by Mail

#### **Application Checklist**

#### **Applications are legal documents**

- \_\_\_\_\_ All required blanks are complete – typed or in blue or black ink (corrections made with fluid or tape are not permitted)
- \_\_\_\_\_ License number and Check mark by all licenses you wish to renew
- \_\_\_\_\_ Application is signed and dated
- \_\_\_\_\_ All attached pages signed and dated
- \_\_\_\_\_ Continuing education approved by board of nursing or national nursing organization/association and at least 1 contact hour in length
- \_\_\_\_\_ Appropriate fee is attached (total fees for all licenses)
- \_\_\_\_\_ All required additional documents are attached
- \_\_\_\_\_ Military orders are attached if you are renewing following active military service and wish to defer CE requirements

**All information on the attached application must be complete and accompanied by the appropriate fee. All blanks must be complete unless otherwise noted (e.g. optional). Mail the original application you completed; no photocopies of completed applications are accepted.**

Application fees may be paid by personal check, money order or cashiers check made payable to the Kansas State Board of Nursing. The application fee must accompany the application

**DO NOT SEND COPIES OF CONTINUING NURSING EDUCATION.** If selected for an audit of continuing nursing education hours, notification will be received by mail. Nurses selected for an audit are given 21 days to submit copies of continuing nursing education certificates to the Board.

***Please allow two weeks for the processing of your Renewal Application. If the renewal application is not postmarked by the last day of the renewal month, reinstatement will be required and you will be unable to practice in Kansas until reinstatement is complete.***

### **Requirements for Additional Documents:**

- **CHANGE OF NAME:** Submit to the Board a notarized Change of Name Certificate (available in the forms section at [www.ksbn.org](http://www.ksbn.org)) or the certified legal document (i.e., marriage certificate, divorce decree) with Application.
- **Military Orders:**
  - Currently on Active Duty: The provisions of KSA 48-3402 continue an active license while on active duty. If you are on active duty; please submit a certified copy of active duty papers. According to KSA 48-3404, this provision does not apply if you practice outside of the line of duty in the military service.
  - Recently discharged from Active Duty: The provisions of KSA 48-3403 allow for renewal of a license for a period of 6 months after discharge from active duty; if engaged in the practice of nursing in Kansas, the renewal must be submitted within 2 weeks after engaging in practice. Continuing education is not required for the renewal within 6 months of discharge from active duty. If you have been recently discharged, please submit a certified copy of discharge papers.
  - **Please note:** If you work more than 2 weeks following discharge without submitting a renewal application it is considered “unlicensed practice”.
- **CONVICTIONS:** If you have been **convicted** of a misdemeanor and/or felony, specific **certified/dated** copies of court documents (for EACH) conviction are **REQUIRED** when you submit your application. The certified/dated copies must be current (dated within the past 3 months). Without the REQUIRED documents, the application is considered incomplete and may result in a denial of licensure. (Note if previously submitted to KSBN and give KSBN case number. Do not send a second copy.)  
**Please note:** a successfully completed court-ordered Diversion is NOT a conviction, and therefore need not be reported to KSBN. Also note that different courts may use different titles for similar court documents.

The following list is not all inclusive but represents the types of court documents that can be obtained from the office of the Clerk of the Court where the conviction/diversion occurred – City (municipal), county (district/circuit) or federal court:

- Uniform Notice to Appear and Complaint (e.g. ticket), Complaint/Petition or Indictment:  
DO NOT submit information regarding speeding or parking tickets
  - Amended Complaint/Petition or Indictment (indicates charges were increased/decreased from the original charges)
  - Journal Entry of Judgment (Conviction) and Sentencing (this may be on the back side of the ticket or a separate piece of paper entitled “Journal Entry”)
  - Probation Agreement (if any) and current status
  - Diversion Agreement (if any) and current status
  - Proof that all fines, fees, costs and/or restitution have been paid or record of payment to date
- **DISCIPLINARY ACTION:** If you have been **disciplined** by any other Board (e.g professional licensure) or governmental agency (e.g. Department of Health and Environment regarding CNA or HHA certification, Department of Revenue regarding a driver’s license suspension, cancellation and/or revocation for any reason), you are **REQUIRED** to provide a certified/dated copy of that Board order or disciplinary/administrative action. You may obtain a copy of your current Driver’s record by going to any driver’s license exam station with a current photo ID and requesting the document. A small fee is usually charged for a copy of your driving record. (Note if previously submitted to KSBN and give KSBN case number. Do not send a second copy.)
  - **EXPLANATORY LETTER:** You are REQUIRED to submit an explanatory letter regarding EACH conviction and/or disciplinary/administrative action. The letter should include the following information:
    - Date of the criminal offense or disciplinary/administrative action
    - Circumstances leading up to the arrest or disciplinary/administrative action
    - Actual conviction or disciplinary/administrative action
    - Actual sentence or board/regulatory agency order
    - Current status of sentence or order
    - Rehabilitation (if any)

**If you have questions about the conviction or disciplinary action requirements, please contact the Kansas State Board of Nursing legal department at (785) 296-4325.**

RN/LPN/LMHT Survey

Name: \_\_\_\_\_

License Number: \_\_\_\_\_

NOTE: The Kansas Legislature has determined that information regarding the trends in use and availability of health care services is urgently needed for improved decision-making. The following information will be provided to the Kansas Health Care Data Governing Board. Please complete the questionnaire as accurately as possible. Statistics derived from this information will be utilized to make future statewide health workforce planning decisions. The information you provide will be confidential and will not be disclosed except as provided by KSA 1997 Supp. 45-221 et seq.

EMPLOYMENT

- 1. How many hours of direct patient care do you provide in total in Kansas in a typical week? ... Hours
(Use a whole number or decimal rather than a range i.e., 40 hours. Do not use <, >, or +). Direct patient care means service medical provided to an individual patient, including personal contact, telephone consultations and related record keeping. It excludes time spent on call and in providing training, teaching or research).
2. Of the hours that you work in a typical week, how many hours are in: Administration, Research, Teaching
3. Do you provide nursing or mental health technician services in Kansas? Yes No

If no, you do not need to complete the remainder of this form.

DIRECT PATIENT CARE PRACTICE SITE #1: (principal practices site - May be an office, hospital, nursing facility, etc.)

4. Address: Agency Name Street Address
City County State Zip Code+4 Phone Number

- 5. What type of work setting is practice site #1? (Please use the appropriate code found on the last page)
6. How many hours per week of direct patient care do you provide at practice site #1 in a typical week? ... Hours
(Use a whole number or decimal rather than a range i.e., 40 hours. Do not use <, >, or +).
7. Do you have another practice site? Yes No

DIRECT PATIENT CARE PRACTICE SITE #2: (This may be an office, hospital, nursing facility, etc.)

8. Address: Agency Name Street Address
City County State Zip Code+4 Phone Number

- 9. What type of work setting is practice site #2? (Please use the appropriate code found on the last page)
10. How many hours per week of direct patient care do you provide at practice site #2 in a typical week? ... Hours
(Use a whole number of decimal rather than a range i.e., 40 hours. Do not use <, >, or +).
11. Do you have another practice site? Yes No



## ARNP Survey

**Name:** \_\_\_\_\_ **License Number:** \_\_\_\_\_

NOTE: The Kansas Legislature has determined that information regarding the trends in use and availability of health care services is urgently needed for improved decision-making. The following information will be provided to the Kansas Health Care Data Governing Board. Please complete the questionnaire as accurately as possible. Statistics derived from this information will be utilized to make future statewide health workforce planning decisions. The information you provide will be confidential and will not be disclosed except as provided by KSA 1997 Supp. 45-221 *et seq.*

### EMPLOYMENT

1. How many hours of direct patient care do you provide in total in Kansas in a typical week? ..... \_\_\_\_\_ Hours  
(Use a whole number or decimal rather than a range i.e., 40 hours. Do not use <, >, or +). Direct patient care means service medical provided to an individual patient, including personal contact, telephone consultations and related record keeping. It excludes time spent on call and in providing training, teaching or research).
2. Of the hours that you work in a typical week, how many hours are in: Administration \_\_\_\_\_  
Research \_\_\_\_\_  
Teaching \_\_\_\_\_
3. Do you provide nursing or mental health technician services in Kansas? \_\_\_\_ Yes \_\_\_\_ No
4. Check the following category(ies) for which you are certified?  
 Clinical Nurse Specialist       Nurse Clinical/Nurse Practitioner  
 Nurse Anesthetist             Nurse Midwife
5. Please indicate your practice specialties (please use the specialty codes on the **last page**).  
 Specialty Code #1 \_\_\_\_\_ Specialty Code #2 \_\_\_\_\_ Specialty Code #3 \_\_\_\_\_

### **DIRECT NURSING CARE PRACTICE SITE #1:** (This may be an office, hospital, nursing facility, etc.)

6. Address:  
 Agency Name      Street Address Suite/Apt      City      County      State      Zip Code+4      Phone Number  
 \_\_\_\_\_ ( ) \_\_\_\_\_
7. What kind of work setting is practice site #1? (Please use the appropriate code found on the **last page**) \_\_\_\_\_
8. How many hours per week of **direct nursing care** do you provide at practice site #1 in a typical week? ..... \_\_\_\_\_ Hours  
(Use a whole number or decimal rather than a range i.e., 40 hours. Do not use <, >, or +).
9. Of the hours you spend in **direct nursing care** at practice site #1, what percentages are in  
 (Please refer to practice specialties you listed in **question 5**)  
 Specialty #1 \_\_\_\_\_%  
 Specialty #2 \_\_\_\_\_%  
 Specialty #3 \_\_\_\_\_%  
100%
10. Which of the following statements best describes your practice at site #1? \_\_\_\_\_  
 a. I am not working in advanced practice.  
 b. I am employed by a physician at practice site #1.  
 c. I am employed by a physician who is at a practice location other than practice site #1.  
 d. I am employed by an organization/institution at practice site #1.  
 e. I am self-employed at practice site #1 with physician protocols.  
 f. I am self-employed at practice site #1 without physician protocols.  
 g. Other (specify) \_\_\_\_\_
11. At this practice site, how many patients do you see during an average week? \_\_\_\_\_
12. List the full name(s) and addresses of the physicians you work in association with through practice site #1:  
 Physician #1

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Full Name	Street Address	City	State
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Physician #2

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Full Name	Street Address	City	State
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Physician#3

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Full Name	Street Address	City	State
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13. Do you have another practice site in Kansas? \_\_\_\_\_ Yes \_\_\_\_\_ No

**DIRECT NURSING CARE PRACTICE SITE #2:** (This may be an office, hospital, nursing facility, etc.)

14 Address: Agency Name Street Address Suite/Apt City County State Zip Code+4 Phone Number  
\_\_\_\_\_ ( ) \_\_\_\_\_

15. What kind of work setting is practice site #2? (Please use the appropriate code found on the **last page**) \_\_\_\_\_

16 How many hours of **direct nursing care** per week do you provide at practice site #2 in a typical week? ..... \_\_\_\_\_ Hours  
(Use a whole number or decimal rather than a range i.e., 40 hours. Do not use <, >, or +).

17. Of the hours you spend in **direct nursing care** at practice site #2, what percentages are in Specialty #1 \_\_\_\_\_%  
(Please refer to practice specialties you listed in **question 5**) Specialty #2 \_\_\_\_\_%  
Specialty #3 \_\_\_\_\_%  
100%

18. Which of the following statements best describes your practice at site #2? \_\_\_\_\_  
a. I am not working in advanced practice.  
b. I am employed by a physician at practice site #2.  
c. I am employed by a physician who is at a practice location other than practice site #2.  
d. I am employed by an organization/institution at practice site #1.  
e. I am self-employed at practice site #2 with physician protocols.  
f. I am self-employed at practice site #2 without physician protocols.  
g. Other (specify) \_\_\_\_\_

19. At this practice site, how many patients do you see during an average week?..... \_\_\_\_\_

20. List the full name(s) and addresses of the physicians you work in association with through practice site #2:  
Physician #1

\_\_\_\_\_ Full Name Street Address City State  
Physician #2

\_\_\_\_\_ Full Name Street Address City State  
Physician

#3 \_\_\_\_\_ Full Name Street Address City State

21. Do you have another practice site in Kansas? \_\_\_\_\_ Yes \_\_\_\_\_ No

**DIRECT NURSING CARE PRACTICE SITE #3:** (This may be an office, hospital, nursing facility, etc.)

22. Agency Name Street Address Suite/Apt City County State Zip Code+4 Phone Number  
\_\_\_\_\_ ( ) \_\_\_\_\_

23. What kind of work setting is practice site #3? (Please use the appropriate code found on the **last page**) \_\_\_\_\_

24. How many hours per week of **direct nursing care** do you provide at practice site #3 in a typical week? ..... \_\_\_\_\_ Hours  
(Use a whole number or decimal rather than a range i.e., 40 hours. Do not use <, >, or +).

25. Of the hours you spend in **direct nursing care** at practice site #3, what percentages are in Specialty #1 \_\_\_\_\_%  
(Please refer to practice specialties you listed in **question 5**) Specialty #2 \_\_\_\_\_%  
Specialty #3 \_\_\_\_\_%  
100%

26. Which of the following statements best describes your practice at site #3? \_\_\_\_\_  
a. I am not working in advanced practice.  
b. I am employed by a physician at practice site #3.  
c. I am employed by a physician who is at a practice location other than practice site #3.  
d. I am employed by an organization/institution at practice site #1.  
e. I am self-employed at practice site #3 with physician protocols.  
f. I am self-employed at practice site #3 without physician protocols.  
g. Other (specify) \_\_\_\_\_

27. At this practice site, how many patients do you see during an average week?..... \_\_\_\_\_

28. List the full name(s) and addresses of the physicians you work in association with through practice site #3:  
Physician #1

Full Name	Street Address	City	State
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Physician #2`

Full Name	Street Address	City	State
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Physician #3

Full Name	Street Address	City	State
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29. Do you have another practice site in Kansas? \_\_\_\_Yes \_\_\_\_No

30. If you answered Yes to question 29 how many other practice sites do you have in Kansas?\_\_\_\_\_

31. If you answered Yes to question 29, how many hours in total of **direct nursing care** in a typical week do you provide in all of your other practice sites included on question 29? ..... \_\_\_\_\_Hours  
(Use a whole number or decimal rather than a range i.e., 40 hours. Do not use <, >, or +).

### Specialty Codes for Question 20

- |                                   |                               |                        |
|-----------------------------------|-------------------------------|------------------------|
| 1. Adult                          | 12. Emergency                 | 23. Obstetrics and GYN |
| 2. Adult/Medical-Surgical         | 13. Family Planning           | 24. Oncology           |
| 3. Adult Mental Health/Psychiatry | 14. Family                    | 25. Orthopedics        |
| 4. Anesthesiology                 | 15. Gerontology               | 26. Prenatal           |
| 5. Cardiology                     | 16. Gynecology                | 27. Preoperative       |
| 6. Cardiovascular                 | 17. Maternal Child            | 28. Primary Care       |
| 7. Child or Pediatrics            | 18. Maternity/pediatrics      | 29. Rehabilitation     |
| 8. Child Mental Health/Psychiatry | 19. Medical Surgical          | 30. Rheumatology       |
| 9. Community Health               | 20. Mental Health/Psychiatric | 31. Women=s Health     |
| 10. Critical Care                 | 21. Neonatal                  | 32. Other (specify)    |
| 11. Diabetes                      | 22. Nurse Midwife             | _____                  |

### Work Setting Codes (Questions 22, 31 and 39)

- |  |   |
|--|---|
| 1. Administrative/Regulatory Agency              | 23. Pharmacy  |
| 2. Ambulance Company                             | 24. Radiology/Imaging Center  |
| 3. Ambulatory Surgery Center                     | 25. Rehabilitation Hospital   |
| 4. Assisted Living Facility                      | 26. Residential Treatment Center for Emotionally or Mentally Disturbed Children |
| 5. Business/Industrial Establishment             | 27. Rural Health Clinic   |
| 6. Correctional Institution                      | 28. School District or Ed. Coop   |
| 7. County Mental Hospital - Inpatient Unit       | 29. School Clinic Service Env.  |
| 8. Emergency Room only                           | 30. State or Community Mental Health Facility                                   |
| 9. Federal Hospital or Facility                  | 31. State or Community Mental Retardation Facility                              |
| 10. Federally Qualified Health Center            | 32. State Governmental Agency   |
| 11. Free Standing Clinic                         | 33. State Mental Hospital Inpatient Unit  |
| 12. General Hospital                             | 34. Teaching Hospital   |
| 13. HMO/Insurance Company                        | 35. University or College   |
| 14. Home Health Agency                           | 36. Youth Detention Facility  |
| 15. Hospital ( provides inpatient services only) | 37. Other (Specify)   |
| 16. Independent Laboratory                       |   |
| 17. Independent Living Center                    |   |
| 18. Indian Health Center                         |   |
| 19. Individual Practitioner's Office             |   |
| 20. Local Health Department                      |   |
| 21. Nursing/Long Term Care Facility              |   |
| 22. Partnership/Group Practice Office            |   |

