

**KANSAS STATE BOARD OF NURSING**  
**Landon State Office Building**  
**900 SW Jackson, Ste 1051**  
**Topeka, KS 66612-1230**

**REINSTATEMENT APPLICATION**

<b>Please write LICENSE NUMBER in the blank and CHECK ALL that apply</b>	
<b>Example: RN: <u>13-12345-678</u> \$150 <input checked="" type="checkbox"/></b>	
LPN with Temporary Permit: _____	\$150 _____
LPN without Temporary Permit: _____	\$150 _____
RN with Temp Permit: _____	\$150 _____
RN without Temp Permit: _____	\$150 _____
APRN without Temporary Permit _____	\$75 _____
RNA with Temporary Permit _____	\$70 _____
RNA without Temporary Permit: _____	\$60 _____
LMHT with Temporary Permit _____	\$75 _____
LMHT without Temporary Permit _____	\$70 _____
<b>TOTAL</b>	<b>\$ _____</b>

**Demographic Information:**

**Name:**

Do not use nicknames. If you do not have a middle name, leave the field blank. If you have just an initial for a first or middle name, write just the initial in the corresponding field.

\_\_\_\_\_  
**Last Name                      First Name                      Middle Name/Middle Initial**

\_\_\_\_\_  
**Previous Name (s)**

\_\_\_\_\_  
**Mailing Address**

\_\_\_\_\_  
**City                                      State                                      Zip Code**

1. Date of Birth (MM) \_\_\_\_ (DD) \_\_\_\_ (YYYY) \_\_\_\_ Gender: Male: \_\_\_\_ Female: \_\_\_\_

2. Place of Birth: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

3. Social Security No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **Social Security Number Required**  
 (Your social security number is required pursuant to 42 U.S.C.s 666(a), 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)

4. Ethnic Information:    \_\_\_\_ African American            \_\_\_\_ Asian Indian  
                                   \_\_\_\_ Native American            \_\_\_\_ Asian - Other  
                                   \_\_\_\_ Hispanic                        \_\_\_\_ Pacific Islander  
                                   \_\_\_\_ White-Non Hispanic        \_\_\_\_ Other

5. Phone: Home (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell (\_\_\_\_) \_\_\_\_ - \_\_\_\_ E-Mail \_\_\_\_\_

6. Are you a military service member? \_\_\_\_ Yes \_\_\_\_ No

7. Are you a spouse of a military service member? \_\_\_\_ Yes \_\_\_\_ No

8. Have you established or intend to establish residency in Kansas? \_\_\_\_ Yes \_\_\_\_ No

9. Do you wish to obtain a 120-Day temporary Permit to complete your 30 hours of CE? *(if granted, temporary permit is for single state to practice in Kansas only)*  
\_\_\_\_ Yes \_\_\_\_ No

10. **LPN Only:** Are you IV certified in another state? \_\_\_\_ Yes \_\_\_\_ No

If certified in another state, you must complete the KSBN IV Therapy application (available at [https://ksbn.kansas.gov/wp-content/uploads/IV\\_Therapy/INDIVIDUAL-APPROVAL-LPN-IV-Therapy.pdf](https://ksbn.kansas.gov/wp-content/uploads/IV_Therapy/INDIVIDUAL-APPROVAL-LPN-IV-Therapy.pdf)) and attach a copy of the course syllabus and certificate of completion

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### **Employment History:**

11. Have you worked as an LPN, RN, LMHT or APRN (NP, RNA, CNS, NMW) over the last 5 years?  
Yes \_\_\_\_ No \_\_\_\_ If yes, list **ALL** NURSING employment for the last five (5) years: **(If additional pages need, sign and date each attached page.)**

<b>Name and Complete Address of Employer</b>	<b>Dates of Employment</b>	<b>Reason(s) for Leave</b>	<b>Contact Info:</b>
Employer Name _____ Mailing Address _____ City _____ ST _____ Zip _____	Start Date (mm/yyyy) _____ Last Date Worked (mm/yyyy) _____	_____	Contact Name _____ Contact Phone Number _____
Employer Name _____ Mailing Address _____ City _____ ST _____ Zip _____	Start Date (mm/yyyy) _____ Last Date Worked (mm/yyyy) _____	_____	Contact Name _____ Contact Phone Number _____
Employer Name _____ Mailing Address _____ City _____ ST _____ Zip _____	Start Date (mm/yyyy) _____ Last Date Worked (mm/yyyy) _____	_____	Contact Name _____ Contact Phone Number _____

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### **Misdemeanor/Felony/Disciplinary Information:**

**If you answer "yes" to any misdemeanor/felony/disciplinary question(s) on this application or have a criminal history on your background/history the required documentation must be received**

**by the KSBN or your application will be considered incomplete and cannot be processed by the KSBN. If you have questions about the conviction or disciplinary action requirements, please contact the KSBN Legal Department at 785-296-4325. Review the information about legal information for an explanation about the documentation that needs to be submitted if you answer "yes" to any of the following legal questions.**

12. Since your last application, have you been convicted of a felony?  
 Yes  No
13. Since your last application, have you been convicted of a misdemeanor?  Yes  No
14. Since your last application, do you have any pending criminal case against you for a felony offense or a misdemeanor offense?  
 Yes  No
15. Do you presently have any physical or mental problems or disabilities or abuse of drugs or alcohol that could affect your ability to practice nursing competently and safely?  
 Yes  No  
*(If yes, submit an explanatory letter and physician's release)*
16. Since your last application, have you had a license to practice nursing denied, revoked, limited, or suspended or publicly or privately censured by a licensing authority?  Yes  No
17. Since your last application, have you had disciplinary action taken against you by a professional licensing authority?  Yes  No
18. Are you registered, certified, or licensed in any other profession?  Yes  No  
If yes, list profession(s) \_\_\_\_\_
19. Since your last application, have you voluntarily surrendered any professional license while an investigation or discipline case was pending?  Yes  No
20. Since your last application, have you allowed any professional license to expire while an investigation or discipline was pending?  Yes  No
21. Do you have any pending investigations or disciplinary cases against you or your license, certification, or registration by a professional licensing authority?  Yes  No

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22. Are you currently participating in a monitoring program approved by a licensing board?  
 Yes  No

**The following questions must be answered if you are reinstating your Kansas multistate license. Failure to answer these questions will disqualify you from receiving a multistate license.**

**Declaration of Primary State of Residency**

23. To be considered for a multistate license, Kansas must be your primary state of residency. I declare Kansas as my primary state of residence and I am providing a Kansas address.  Yes  No  
*If you do not have a current Kansas mailing address, you must provide one of the documents in the section titled Declaration or Primary State of Residence in the instructions. If Kansas is not your primary state of residence, you are not eligible for a Kansas multistate license.*

24. Do you hold an active Nurse Licensure Compact multistate license in another state?  
 Yes  No

*A nurse may only hold one multistate license. If you currently hold a multistate license in another jurisdiction and you are not changing your primary state of residence to Kansas you should not submit an application for a multistate license.*

25. Are you currently participating in a monitoring program approved by a licensing board?  
 Yes  No

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**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)**

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

Date of Licensure: \_\_\_\_\_ License Number: \_\_\_\_\_