Kansas

EXPEDITED LICENSURE QUESTIONNAIRE

To determine if you are eligible for expedited licensure pursuant to K.S.A. 48-3406', please answer the following questions. If it is determined that your responses were intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military/law enforcement agencies.

1. Are you a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes ☐ No ☑ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

2. Are you the spouse of a current member of any branch of the United States armed services, United States military reserves, national guard of any state, or a former member with an honorable discharge? Yes☐ No☑ If yes:

   Branch:_____ Dates of Service:_____ Military ID#:_____

3. Do you currently reside in Kansas? Yes☐ No☑ If yes:

   Current Kansas Residence Address:_____

4. If you do not currently reside in Kansas, do you intend* to establish residency in Kansas within the next 6 months? ***If you answer "yes" to this question but do not establish Kansas residency within the next 6 months, your Kansas license will be cancelled. If it is determined that your answer to this question was intentionally false or misleading, you will be subject to an administrative disciplinary action in Kansas and will be reported to all appropriate state/federal/military agencies in other jurisdictions.*** Yes ☐ No ☑ If yes:

   Intended Kansas Residence Address:_____

   Expected Date of Commencing Residence:_____

If you answered "no" to all questions #1 through #4, you do not need to answer questions #5 through #7.

5. Are you currently licensed, registered, or certified to practice (the profession for which you are seeking licensure in Kansas) by another state, district, or territory of the United States and have worked under that license for at least 1 year. ***This does not include certifications or registrations issued by private boards, professional societies, or any organization other than a government body of a state, district, or territory of the U.S.*** Yes☐ No☐ If no:

   a. Have you practiced the profession for which you are seeking licensure in Kansas for at least 3 years in a state that does not license/register/certify the profession? Yes ☐ No☐

   b. Have you practiced the profession for which you are seeking licensure in Kansas for at least 2 years in a state that does not license/register/certify the profession and you held a certification or registration issued by a private organization during those 2 years? Yes☐ No☐ If yes:

      Organization that issued private certification/registration: _____ Date Issued: _____

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

Kansas

*** "Active practice" does not include care provided while in a training program, residency, or fellowship; or employment that consisted solely of research activities or administrative duties. The Board generally considers active practice to be direct patient care that for either (1) at least one full day per week for 50 weeks during a year; or (2) 400 hours during a year.**

6. Have you actively practiced* the profession for which you are seeking licensure in Kansas during the last 2 years? Yes☐ No☐

If you answered "yes" to question #6, you do not need to answer question #7.

7. If you answered "No" to questions #6, please provide a detailed explanation regarding your active clinical practice and direct patient care during the 12 months immediately preceding the submission of your application. Please explain any gaps in active practice in the 12 months immediately preceding the submission for your application, including the amount of time and reason.

[i] An applicant who has not been in the active practice of their occupation during the two years preceding the application for which a license is sought, may be required to complete additional testing, training, monitoring or continuing education as the KSBHA deems necessary to establish present ability to practice in a manner that protects the health and safety of the public K.S.A. 48-3406(d).

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Uniform Application – Core Application

Applicant: Follow the instructions given in the left sidebar of each page.
Send this application to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Indicate your full legal name and any other names you have used in the past. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change to the Board.

Full Name

Last name: Block Suffix:
First name: Alison
Middle name: Diana
Maiden name (if applicable):
All other names used/identified as:

Degree Type ☐ M.D. ☐ D.O.

Please complete all fields and Indicate which address you want to use for public access and at which address you want to receive mailings from the Board. Addresses may vary on which address or phone number is or is not a matter of public record. Additionally, many state boards publish the Public Access address on their web sites. You may wish to contact the appropriate state licensing authority to determine which information will be a matter of public record.

Practice Address

■ Public Access
☐ Mailings for Medical Board

Street: 5107 E. Kellogg Dr.
City: Wichita
State/Province: KS
Zip code: 67218 Country: USA
Practice phone: 316-260-6934 Practice fax: 316-425-3451
Alternate phone: Alternate fax:
Practice email: admin@southwindwomenscenter.org

Home Address

☐ Public Access
■ Mailings for Medical Board

CONFIDENTIAL

If you are not using FCVS, you must submit one of the following to the Board: certified birth certificate, notarized copy of your birth certificate, original valid passport, or notarized copy of your current valid passport. Please check the state specific instructions for more information.

Identification

Date of birth: CONFIDENTIAL (mm/dd/yyyy) Gender: F Birth city: New York
Birth state/province: New York Birth country: USA
Social Security number**: CONFIDENTIAL 1679863609 (10 digits) U.S. Citizen? ☑ Yes ☐ No

Be sure to list your name at the top of each following page.

*Your social security [illegible] the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

**The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, visit http://www.cms.hhs.gov/NationalProvIdentStand/

Applicant Name: Alison Block

List all medical schools you have attended, even those from which you did not graduate, in chronological order. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Medical Education Verification form and send it to all medical schools you have attended. Include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to the Board.

Additionally, the medical school must provide the Board with an official copy of your transcripts. If transcripts are not in English, an original, certified, and official English translation is required.

If you attended a Fifth Pathway program and are not using FCVS, you must complete the Fifth Pathway Verification form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical School and institution must forward all documentation directly to the Board.

If ECFMG is applicable and you are not using FCVS, contact ECFMG and have a certified status report forwarded from them to the Board. There is a separate fee for this report.

Medical School

1. Full Name of Medical School: University of California, San Francisco

Street: UCSF Box 0244 500 Pamassus Ave MU-200W

City: San Francisco State/Province: CA Zip code: 94143

Country: USA Attendance dates: From 09/2006 (mm/yyyy) to 06/2011 (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): 6/10/2011 (mm/dd/yyyy)

Degree received (as stated on diploma): MD (Doctor of Medicine) (indicate if not applicable)

2. Full Name of Medical School: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): _____ (mm/dd/yyyy)

Degree received (as stated on diploma): _____ (indicate if not applicable)

Fifth Pathway

☑ I did not participate in a Fifth Pathway program.

Affiliated medical school that awarded the Fifth Pathway Certification

Full Name of Medical School: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)

Date degree conferred/issued: _____ (mm/dd/yyyy) Degree (as stated on diploma): _____

Hospital or clinic in which you performed the required rotations

Institution name: _____

Rotation dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Certificate date: _____ (mm/dd/yyyy)

ECFMG

☑ I do not have an ECFMG certificate.

Certificate number: _____ Issue date: _____ (mm/dd/yyyy)

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Applicant Name: Alison Block

List all postgraduate programs you have attended, even those you did not complete. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Postgraduate Training Verification form and send it to all postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to the Board. The postgraduate program must forward all documentation directly to the Board.

Postgraduate Training

1. Full Name of Hospital: Santa Rosa Family Medicine Program
   Street: 3569 Round Barn Circle Suite 200
   City: Santa Rosa State/Province: CA Zip code: 95403
   Country: USA Department/Specialty: Family Medicine
   Affiliated medical school name: University of California, San Francisco
   Attendance dates: From 06/2011 (mm/yyyy) to 06/2014 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 3

   ■ Chief Resident ☐ Internship/Residency ■ Residency ☐ Transitional
   ☐ Fellowship ☐ Junior Registrar ☐ Residency/Chief Residency
   ☐ Fellowship/Research ☐ Preliminary ☐ Senior House Officer ☐ Unknown
   ☐ House Officer ☐ Registrar ☐ Senior Registrar ☐ Unspecified
   ☐ Internship ☐ Research ☐ Other: _____

   Successfully completed? ☑ Yes ☐ No ☐ In progress; expected completion in _____ (mm/yyyy)

2. Full Name of Hospital: _____
   Street: _____
   City: _____ State/Province: _____ Zip code: _____
   Country: _____ Department/Specialty: _____
   Affiliated medical school name: _____
   Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): _____

   ☐ Chief Resident ☐ Internship/Residency ☐ Residency ☐ Transitional
   ☐ Fellowship ☐ Junior Registrar ☐ Residency/Chief Residency
   ☐ Fellowship/Research ☐ Preliminary ☐ Senior House Officer ☐ Unknown
   ☐ House Officer ☐ Registrar ☐ Senior Registrar ☐ Unspecified
   ☐ Internship ☐ Research ☐ Other: _____

   Successfully completed? ☑ Yes ☐ No ☐ In progress; expected completion in _____ (mm/yyyy)

3. Full Name of Hospital: _____
   Street: _____
   City: _____ State/Province: _____ Zip code: _____
   Country: _____ Department/Specialty: _____
   Affiliated medical school name: _____
   Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): _____

   ☐ Chief Resident ☐ Internship/Residency ☐ Residency ☐ Transitional
   ☐ Fellowship ☐ Junior Registrar ☐ Residency/Chief Residency
   ☐ Fellowship/Research ☐ Preliminary ☐ Senior House Officer ☐ Unknown
   ☐ House Officer ☐ Registrar ☐ Senior Registrar ☐ Unspecified
   ☐ Internship ☐ Research ☐ Other: _____

   Successfully completed? ☐ Yes ☐ No ☐ In progress; expected completion in _____ (mm/yyyy)

Applicant Name: Alison D. Block

List the information for each licensure exam you have taken, whether U.S. or international (USMLE, LLMCC, NBME, etc.).

If you are not using FCVS, you must contact the appropriate examination entity and have them send a certified transcript of your scores directly to the Board.

Examination History

Examination	Most recent date taken (mm/yyyy)	Passed/Failed/Unknown	Number of attempts
FLEX Pre-1985		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 1		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 2		☐ (P) ☐ (F) ☐ (U)	
LMCC – Single		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part I		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part I		☐ (P) ☐ (F) ☐ (U)	
NBME Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part III		☐ (P) ☐ (F) ☐ (U)	
SPEX		☐ (P) ☐ (F) ☐ (U)	
NBOME Part I		☐ (P) ☐ (F) ☐ (U)	
NBOME Part II		☐ (P) ☐ (F) ☐ (U)	
NBOME Part III		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 1		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, CE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, PE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 3		☐ (P) ☐ (F) ☐ (U)	
COMVEX		☐ (P) ☐ (F) ☐ (U)	
USMLE Step I	03/2008	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CS	08/2009	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CK	07/2009	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step III	12/27/2011	☑ (P) ☐ (F) ☐ (U)	1
State Board Exam State: CA	12/2013	☑ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	

List all state and Canadian provinces where you currently hold or have ever held any type of health care related license. Please copy and attach additional pages if necessary.

You must also complete the Licensure Verification form and send it to all states in which you have held any health care license or certification. Some state boards charge a fee for this information. The verifying entity must forward all licensure documentation to the Board.

State/Province Professional Licensure

1. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

- ■ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: California License number: A 122363 Issue date: 08/03/2012

License status: ■ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

Applicant Name: Alison D. Block

Please copy and attach additional pages if necessary.

2. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic
☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

3. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic
☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

4. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic
☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

5. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic
☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

Applicant Name: Alison D. Block

List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

*Also list your permanent or home address for each non-working time.

If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.

DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS SECTION.

Copy and attach additional pages as necessary.

** Clinical indicates the percentage of time spent with patients.

*** Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

Chronology of Activities

1. Start date: 06/2011 (mm/yyyy) End date: 06/2014 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ■ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Santa Rosa Family Medicine Program

Street: 3569 Round Barn Circle Suite 200

City: Santa Rosa State/Province: CA Zip code: 95403

Country: USA Position: Resident

Department: Family Medicine Clinical**: 90 % Administrative***: 10 %

■ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

2. Start date: 09/2014 (mm/yyyy) End date: Present (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ■ Work

Practice/Employment Name or Description of non-working time*: Contra Costa Regional Medical Center

Street: 2500 Alhambra Avenue

City: Martinez State/Province: CA Zip code: 94553

Country: Position: Staff Physician

Department: Family Medicine Clinical**: 50 % Administrative***: 50 %

■ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

3. Start date: 9/2014 (mm/yyyy) End date: Present (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ■ Work

Practice/Employment Name or Description of non-working time*: Planned Parenthood NorCal

Street: 2185 Pacheco Street

City: Concord State/Province: CA Zip code: 94520

Country: USA Position: Contract Physician/Trainer

Department: Family Medicine Clinical**: 100% Administrative***: 0 %

■ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

Applicant Name: Alison D. Block

Copy and attach additional pages as necessary.

4. Start date: _____ (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

5. Start date: _____ (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

6. Start date: _____ (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

Please copy and attach additional pages as necessary.

Applicant Name: Alison D. Block

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

☑ I have not had any malpractice claims or suits made against me.

1. Name of patient involved: _____

In which state, territory, or province did the action take place? _____

Which court*? _____

Case number (if applicable) _____ Month and year of lawsuit: _____

Month and year of event precipitating claim: _____

Current claim status: ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Open (pending) ☐ Other: _____

Amount of judgment or settlement: $_____ Amount paid on your behalf: $_____

What is/was your status? ☐ Primary Defendant ☐ Co-Defendant ☐ Other (specify): _____

Insurance carrier at the time: _____

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

Complete the forms on the following pages as instructed.

☐ UA Affidavit and Authorization for Release of Information
☐ UA Form #1: Licensure Verification Form
☐ All state-specific forms included with this core application

If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

☐ UA Form #2: Medical School Verification
☐ UA Form #3: Postgraduate Training Verification
☐ UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

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UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Medical School Verification (UA Form #2)

Applicant: Complete this form as instructed in the left sidebar.
Dean or Designated Med School Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

Section 1: Applicant Information

Last name: Block Suffix: _____

First name: Alison

Middle name: Diana

Name if different when diploma awarded: _____

Name of medical school: University of California, San Francisco
CONFIDENTIAL CONFIDENTIAL

Date of birth _____ Social Security number*: _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: _____ **Date:** 1/12/22

Dean or Designated Official:

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the Kansas State Board of Healing Arts at the address listed in Section 1. Do not mail this form to FCVS/FSMB.

If transcripts are not in English, an original, certified, and official English translation is required.

Section 2: Medical School Verification

Medical school name: University of California, San Francisco

School name if different when the above applicant attended: _____

Medical school address (including city, state or province, zip code, and country as applicable):
513 Parnassus Avenue
San Francisco, CA 94133

Hours of undergraduate education required for admission into your school: _____

Total weeks of education applicant attended your school: 191

Applicant's attendance dates: From 09/06/2006 to 06/10/2011

Graduation date: 06/10/2011 (indicate N/A if not applicable) Degree: MD (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

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Applicant Name: Alison Block

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes [X] No [ ]

   If yes, please select the reason(s), indicate the dates of the interruption(s) or extension(s), and indicate whether the interruption(s)/ extension(s) was/were approved or unapproved.

	From Month/Year	To Month/Year	Approved	Unapproved
[ ] Personal/Family			[ ]	[ ]
[ ] Academic remediation			[ ]	[ ]
[ ] Health			[ ]	[ ]
[ ] Financial			[ ]	[ ]
[ ] Participation in joint degree program (e.g., MD/PhD)			[ ]	[ ]
[ ] Participation in non-research special study (e.g., fellowship, international experience)			[ ]	[ ]
[X] Other: Research	09/2009	06/2010	[X]	[ ]

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes [ ] No [X]

   If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
[ ] Academic probation		
[ ] Probation for unprofessional conduct/behavioral reasons		
[ ] Probation for other reason(s) (please specify):		

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes [ ] No [X]

   If yes, please attach documentation/information of the circumstances and outcome(s).

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Yes [ ] No [X]

   If yes, please attach documentation/information of the circumstances and outcome(s).

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes [ ] No [X]

   If yes, please attach documentation/information of the nature of the limitations or special requirements.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____

Print name: John Davis, PhD, MD

Title: Associate Dean, Curriculum

Date: 2/2/2022

Phone number: 415-502-1045 Fax number: _____

Email: Franchesca.Torres@ucsf.edu

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Seal Verified KSBHA

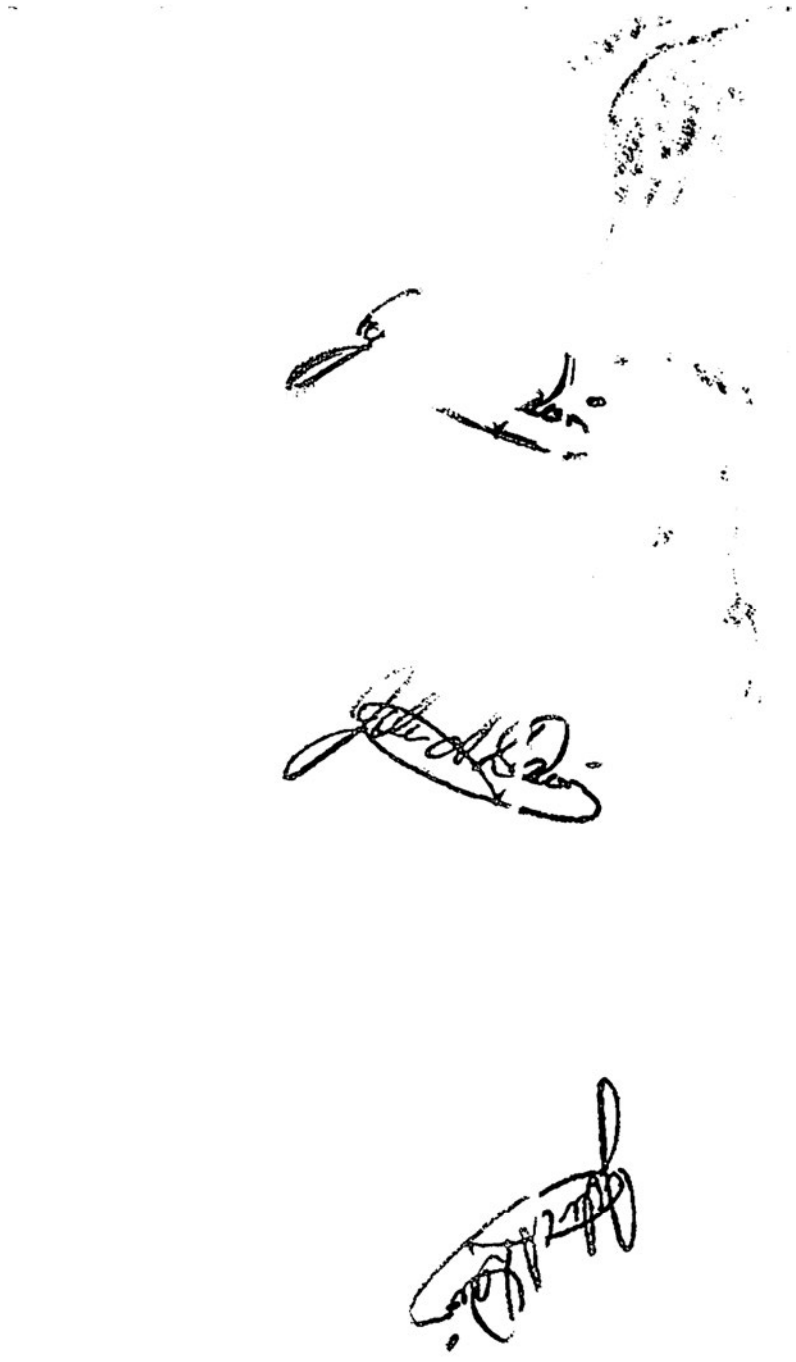
UCSF
University of California
San Francisco

0150
School of Medicine
Medical Student Experience
UCSF Box 0410
513 Parnassus Avenue, S-221
San Francisco, CA 94143

OAKLAND CA 945
4 FEB 2022 PM 6 L

Kansas State Board
of Healing Arts
800 SW Jackson
Lower Level - Suite A
Topeka, KS 66612

66612-124473



CONFIDENTIAL

UCSF
University of California
San Francisco

TRANSCRIPT INFORMATION

GRADUATE DIVISION AND SCHOOLS OF DENTISTRY, NURSING, AND PHARMACY			
Grade	*Points*	*Explanation*	
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C	2.0	**Fair**	
D	1.0	**Barely Passing**	
F	0.0	**Fail**	
H	–	**Honors** *(Dentistry only, in third and fourth years)*	
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	0.0	**Provisional non-passing grade** *(Pharmacy: Students admitted prior to summer 2018)*	
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IP	–	**In Progress.** For courses extending beyond one quarter.	
P/NP	–	**Passed** / **Not Passed** *(Dentistry and Pharmacy)*	
S/U	–	**Satisfactory** / **Unsatisfactory** *(Graduate and Nursing)*	
SP/UP	–	**Satisfactory** / **Unsatisfactory Progress** *(Dentistry)*	
NR	–	**Not Recorded**	

SCHOOL OF MEDICINE		
Grade	*Points*	*Explanation*
P	–	**Passed**
H	–	**Honors.** Awarded in summer term 1992 or later.
I	–	**Incomplete** *(See description in section above)*
IP	–	**In Progress** *(See description in section above)*
E	–	**Provisional Non-Passing**
F	–	**Fail**
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CODE	EXPLANATION
C	Correction
G	Grade assigned, sequence completed
N	Provisional grade removed
R	Repeated course *(Dentistry and Pharmacy)*
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2	Intercampus Exchange
5	UC Berkeley Extension
7	SF Consortium or Stanford Exchange
W	Withdrew from all courses in the term

TRANSCRIPT FORMAT HISTORY

Enrolled prior to Fall Quarter 1978–Photocopy of hard copy.
Enrolled Fall Quarter 1978 or thereafter–Computer-generated transcript (course titles included beginning Fall 2001).

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WITHDRAWAL

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ACCREDITATION

The University of California, San Francisco is accredited by the WASC Senior College and University Commission.

PRIVACY NOTICE

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University of California, San Francisco
Office of the Registrar
UCSF Box 0244
500 Parnassus Avenue, MU-200W
San Francisco, CA 94143
Tel. (415) 476-8280 • Fax (415) 476-9690
http://registrar.ucsf.edu

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- Identifying visible blue and red fibers embedded into the paper.
- Applying fresh liquid bleach to activate a color stain chemical protection reaction.
- Touch, rub, or breathe on TouchSafe® fingerprint verification seal to see hidden message "VALID".
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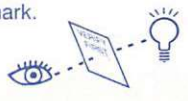
- Inspect background with a magnifier to verify the encrypted NaNOcopy™ algorithm.



U.S. Security Patents: 5,636,874, 5,772,248, 6,692,030 | WWW.ISP-VFT.COM

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Updated Sept. 2019

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San Francisco

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SP/UP	–	**Satisfactory / Unsatisfactory Progress** *(Dentistry)*	
NR	–	**Not Recorded**	

SCHOOL OF MEDICINE		
Grade	*Points*	*Explanation*
P	–	**Passed**
H	–	**Honors.** Awarded in summer term 1992 or later.
I	–	**Incomplete** *(See description in section above)*
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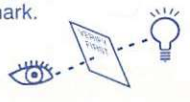

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Updated Sept. 2019

UCSF Office of the Registrar
Student Academic Affairs

UCSF Office of the Registrar
Campus Box 0244
500 Parnassus Ave. MU-200W
San Francisco, CA 94143

Transcript for: **Block, Alison Diana**

Curriculum: Medicine

Delivery Method: FedEx Standard Overnight

Kansas State Board of Healing Arts
800 SW Jackson Street, Lower Level Suite A
Topeka KS 66612

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.
Program Director or Designated Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

Section 1: Applicant Information

Last name: Block Suffix: _____

First name: Alison

Middle name: Diana

Name if different when diploma awarded: _____

Name of postgraduate training program: Santa Rosa Family Medicine Program

CONFIDENTIAL CONFIDENTIAL

Date of birth: _____ Social Security number*: _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: _____ **Date:** 1/12/22

Dean or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

Section 2: Postgraduate Training Verification

Institution name: Sutter Santa Rosa Family Medicine Residency

Institution address: 3569 Round Barn Cirlce, Suite 200

Institution city / state or province / zip code: Santa Rosa, CA 95403

Affiliated medical school name: UCSF

Institution / school name if different when the applicant attended: _____

Postgraduate year (e.g., 1, 2, 3, etc.): 1 ☐ Internship ☑ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7/1/2011 to 6/30/2012

Successfully completed*? ☑ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Applicant Name: Alison Block

Postgraduate year (e.g., 1, 2, 3, etc.): 2 ☐ Internship ☑ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Family Medicine

Attendance dates: From 07/01/2012 to 06/30/2013

Successfully completed*? ☑ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Postgraduate year (e.g., 1, 2, 3, etc.): 3 ☐ Internship ☑ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Family Medicine

Attendance dates: From 07/01/2013 to 06/30/2014

Successfully completed*? ☑ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

1. Did this individual ever take a leave of absence or break from his/her training?	☐ Yes ☑ No
2. Was this individual ever placed on probation?	☐ Yes ☑ No
3. Was this individual ever disciplined or placed under investigation?	☐ Yes ☑ No
4. Were any negative reports for behavioral reasons ever filed by instructors?	☐ Yes ☑ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason?	☐ Yes ☑ No

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____
Print name: Tara Scott, MD
Title: Program Director
Date: 1/27/22
Phone number: 707-583-8800 Fax number: 707-583-8808
Email: scottT3@sutterhealth.org

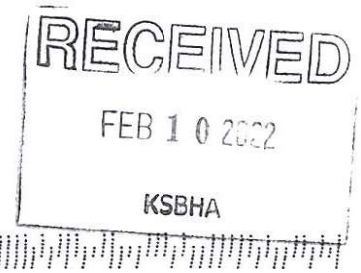
AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Program Director or Designated Official:
Send this form to the Kansas State Board of Healing Arts

family medicine residency
3569 Round Barn Circle, Suite 200
Santa Rosa, CA 95403

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level - Suite A
Topeka, KS 66612



66612B1244 C006

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Recipient: KANSAS STATE BOARD OF HEALING ARTS

Date: 02/27/2022

Examinee: Block, Alison Diana
Alt Name(s):

Examinee ID: 5-206-158-7
Date of Birth: CONFIDENTIAL

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
03/27/2008	Pass	CONFIDENTIAL		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/16/2009	Pass	CONFIDENTIAL		

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
08/18/2009	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
12/27/2011	Pass	CONFIDENTIAL		

End of Exam History

NOTE: The USMLE Step 2 CS examination was last administered March 16, 2020. Examinees with a failing outcome may not have had an opportunity to retest. The USMLE defines successful completion of its examination sequence as passing Step 1, Step 2 CK, and Step 3.

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

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INTERPRETATION OF RESULTS
USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 1 AND STEP 2 CLINICAL SKILLS (CS)
Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score. All Step 2 CS results are reported as pass or fail, with no numeric score. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale.

ANNOTATIONS APPEARING UNDER"COMMENTS"
Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS"NOTE"
Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS"NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this notarized form to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to:

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level - Suite A
Topeka, KS 66612

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's signature (must be signed in the presence of a notary)

RECEIVED
FEB 14 2022
KSBHA

Block
Applicant's printed last name

Alison, D
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

1/25/22
Date of signature (must correspond to date of notarization)

Seal Verified KSBHA

fold up — After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope. — fold up

Notary

State of Kansas, County of Sedgwick,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 25 day of Jan, 2022.

Notary Public Signature:

My Notary Commission Expires: 01/08/2025

(NOTARY PUBLIC SEAL)
STATE OF KANSAS
Stormi Herbison
My Appt. Expires 01/08/2025

ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

Select the discipline applying for and the license designation being requested.

☑ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

☑ Active

A license issued to a person authorizing the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Applicants for active licensure must provide evidence of professional liability insurance (which will be in effect as of the date of licensure) in compliance with Kansas law before a license will be issued. Each active license may be renewed annually. Licensees must maintain and submit evidence of satisfactory completion of a program of continuing education. Licensees must maintain and submit evidence of professional liability insurance, and contribute to the Kansas Health Care Stabilization Fund (more information about this fund can be found here: https://hcsf.kansas.gov/).

☐ Federal Active

A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ Inactive

A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

☐ Exempt

A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

List intended professional activities: _____

Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☑ No
2. Give location of intended practice in Kansas 5107 E. Kellogg Dr. Wichita, KS 67218
3. Primary Specialty Family Medicine

   American Board Certified ABFM American Board Eligible _____

Kansas

ATTESTATION QUESTIONS

Please answer each of the following questions. **All "yes" answers MUST be thoroughly explained in detail on a separate signed page.** You are required to furnish complete details including date, place, reason, and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. **It is imperative you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

If you are unsure of your response to a question, check the "yes" box and submit the appropriate documentation. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty. Please be advised that a false response to any of these questions may be grounds for denial of licensure. If a question is not applicable, then check the "no" box.

Alison D. Block
Full Name of Applicant

1/12/22
Date

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training? Yes ☐ No ☑

2. Have you ever had any application for any professional license refused or denied by any licensing authority? Yes ☐ No ☑

3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? Yes ☐ No ☑

CONFIDENTIAL

4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?

7. Have you ever voluntarily surrendered any professional license? Yes ☐ No ☑

8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held? Yes ☐ No ☑

9. Have you ever been notified or requested to appear before a licensing or disciplinary agency? Yes ☐ No ☑

10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility? Yes ☐ No ☑

Kansas

11. Has any professional association imposed any disciplinary action against you? Yes ☐ No ☑

CONFIDENTIAL

12. Do you have any physical or mental health condition (including alcohol or substance use) that currently impairs your ability to practice your profession in a competent, ethical, and professional manner?

13. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances? Yes ☐ No ☑

14. Have you ever surrendered your state or federal controlled substances registration, or had it revoked, suspended, or restricted in any way? Yes ☐ No ☑

15. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency? Yes ☐ No ☑

16. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes ☐ No ☑

17. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued. Yes ☐ No ☑

18. Have you ever been court martialed or discharged dishonorably from the armed services? Yes ☐ No ☑

19. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself? Yes ☐ No ☑

20. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company? Yes ☐ No ☑

21. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company? Yes ☐ No ☑

It is your continued duty to update the Board on any changes once the application has been submitted.*

RECEIVED
JAN 31 2022
KSBHA

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Kansas State Board of Healing Arts As of Date:1/27/2022

PRACTITIONER INFORMATION

Name: Block, Alison Diana

DOB: CONFIDENTIAL

Medical School: University of California, San Francisco, School of Medicine
San Francisco, California, UNITED STATES

Year of Grad: 2011

Degree Type: MD

NPI: 1679863609

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1679863609	Individual			06/04/2018

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
CALIFORNIA	A-122363	08/03/2012	08/31/2022	01/26/2022

FSMB License Status: Active

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
FB3455880	22N 33N 4 5	SAN PABLO,CA 94806	07/31/2024	01/05/2022
FB9361659	22N 33N 4 5	WALNUT CREEK,CA 94596	07/31/2023	01/05/2022

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Kansas State Board of Healing Arts	As of Date:1/27/2022
Practitioner Name:	Block, Alison Diana	

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Family Medicine
Certificate:	Family Medicine
Certification Type:	General
Certification Status:	Certified
Participating in MOC:	Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	07/01/2014		02/15/2022	Initial	12/30/2021

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34). The Authorized Recipient must submit a new set of fingerprints and fee to receive the updated federal criminal history record.

I have ____ ***OR*** have not X ____ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 5903.

The name, address, and date of birth provided below appear on a valid identification document as defined in Title 28 United States Code, section 1028.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information how to challenge my criminal records for accuracy and completeness.

Signature — Date: 1/12/22

CONFIDENTIAL

Alison D. Block

Printed Name — Date of Birth

CONFIDENTIAL

Residential Address — City — State — Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

Method of Verifying Identity: ☑ Driver's License ☐ State Issued ID Card ☐ Military ID Card

State/Branch: CALIFORNIA ID Number: CONFIDENTIAL

Agency Name: FD SOUTH

Address: 1315 17TH AVENUE, SAN FRANCISCO CA 94122

Telephone: 415. 661. 3005 Fax: 628. 291 7027

Name of Individual Verifying Identity: WILLIE S. MAH

AUTHORIZED RECIPIENT: *1. Must maintain original or arrange for KBI to maintain.*
2. Must provide a copy to the applicant.

CONFIDENTIAL

AMA Physician Profile

PREPARED FOR

Kansas State Board of Healing Arts, Topeka, KS

Name and Mailing Address

ALISON DIANA BLOCK
CONFIDENTIAL

Birth date CONFIDENTIAL

Primary Office Address

2500 ALHAMBRA AVE
MARTINEZ, CA 94553-3156

Phone CONFIDENTIAL

Physician's major professional activity NOT CLASSIFIED

Self-designated practice specialty FAMILY MEDICINE (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1679863609	04/11/2011	NOT RPTD	NOT RPTD	NOT RPTD	01/21/2022

Current and/or historical medical school

UNIVERSITY OF CALIFORNIA SAN FRANCISCO SCHOOL OF MEDICINE

Degree Awarded: YES
Degree Year: 2011

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution:	SUTTER MEDICAL CENTER OF SANTA ROSA
Sponsoring State:	CALIFORNIA
Program name:	SUTTER SANTA ROSA REGIONAL HOSPITAL/UNIVERSITY OF CALIFORNIA (SAN FRANCISCO) PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	
Dates:	7/2011 - 6/2014 (Verified)

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 0

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: AMERICAN BOARD OF FAMILY MEDICINE

Certificate: FAMILY MEDICINE
Certificate type: GENERAL

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
MOC+	Active	07/01/2014	n/a	02/15/2022	INITIAL	02/08/2022	Y

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

+The above certifying board has implemented standards which specify that the board certification is contingent upon meeting ongoing requirements of Maintenance of Certification (MOC). Only certificates issued by a MOC participating board will reflect a reverification date.

Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
122363	MD	CA	08/03/2012	08/31/2022		ACT	UNL	02/03/2022	ALISON DIANA BLOCK

Abbreviation key: ACT = Active, DEN = Denied, INA = Inactive, LIM = Limited, NRT = Not reported, RES = Resident, TEM = Temporary, UNK = Unknown, UNL = Unlimited

Action Notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice.

U.S. Drug Enforcement Administration (DEA)

DEA Number*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address

None Reported

** Only the last three characters of DEA numbers are displayed*

† The Business Activity code and subcode provide additional detail about the physician. For instance, Business Activity code-subcode combinations C-1, C-4, C-5, C-6, C-9, C-A, C-B, C-C, and C-D indicate the physician holds a DEA DATA waiver. Learn more about Business Activity code-subcode combinations.

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

CFMG Certification

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

Profile Information

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission(AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

KAMMCO

On Behalf of Kansas Health Care
Provider Insurance Availability Plan

LETTER OF INTENT

February 17, 2022

Kansas State Board of Healing Arts
800 S.W. Jackson, Lower Level, Ste. A
Topeka, KS 66612

RE: Alison Block, MD

TO WHOM IT MAY CONCERN:

Pending confirmation by the Kansas Health Care Provider Insurance Availability Plan (Plan) from the Kansas Board of Healing Arts (the Board) that Alison Block, MD has been approved for an active Kansas license, the Plan will provide claims-made coverage effective 04/01/2022, with limits of $500,000 per claim/$1,500,000 annual aggregate. This will also confirm that in addition to coverage with the Plan, Dr. Block has selected $500,000 per claim/$1,500,000 annual aggregate limits with the Health Care Stabilization Fund.

Please note this Letter of Intent confers no conditions or obligations on the Plan to provide notice should Dr. Block make the decision not to purchase Plan coverage. Additionally, this letter is not proof of coverage.

Please do not hesitate to contact the Underwriting Department with questions.

Sincerely,

Sara Patry
Underwriter

From: Sara Patry
To: KSBHA_Licensing
Subject: Alison Block, MD - letter of intent attached
Date: Thursday, February 17, 2022 8:32:31 AM
Attachments: email_sig_logo_8c91e9ed-47b3-4b42-a947-0e2fe894c04e1111.png
fb_5760325c-6b93-4e4d-90ae-191c1cb85005111.png
in_d4fdf9ac-bf38-48bc-aca4-2218dc12af9d111.png
Alison Block, MD - letter of intent.pdf

Good morning –

Please see attached for the Plan's letter of intent on Dr. Alison Block, MD.

If you have any questions regarding the attached, please let me know.

Thanks,

KAMMCO

Sara Patry
Underwriter
623 SW 10th Avenue Topeka, Kansas 66612
Office: 785.232.2224 | Fax: 785.232.4704
w: www.KAMMCO.com | e: SPatry@kammco.com

CONFIDENTIAL

Kansas

THIRD PARTY RELEASE

If you would like the Kansas State Board of Healing Arts ("Board") staff to talk with third parties about your application complete this form. This form provides authorization for the Board to release information regarding your application to third parties. This information includes, but is not limited to: application information, license verification, status change, address changes, Kansas Health Care Stabilization Fund information, continuing education information, audit information, and past or current legal issues and documents. This authorization expires one year from the date of signature. You can revoke this authorization at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to receipt of your written request. A reproduction of this authorization shall have the same effect as the original. Email to KSBHA_Licensing@ks.gov or mail it directly to the Board.

I, Alison Block, authorize Board staff to release and discuss any and all information pertaining to my application, with the following individuals:

1. Name: Lizeth Lucio
   Phone: 316-425-3215
   Email: llucio@itrustwomen.org
   Relationship: Credentialing Specialist

2. Name: _____
   Phone: _____
   Email: _____
   Relationship: _____

I acknowledge by my signature, that although I am not required to authorize the Board to release information to third parties, I am giving my consent for Board staff to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information which has already been released with consent, prior to my revocation.

Signature of Applicant

1/12/22
Date

Kansas State Board of Healing Arts
800 SW Jackson – Lower Level, Suite A., Topeka, KS 66612
Phone: (785) 296-7413; Fax: (785) 296-0852; Email: KSBHA_Licensing@ks.gov
www.ksbha.org

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OFFICIAL RECEIPT
KANSAS BOARD OF HEALING ARTS
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612
(785) 296-7413

RECEIPT NUMBER: 687686 DATE: 02/14/2022

NAME:	LICENSE TYPE:	FEE:	LIC #:
ALISON BLOCK		APP $300 KBI $47 NPDB $3	2.14.2022

AMOUNT: 350.00

RECEIVED FROM:

Alison Diana Block
Alison Diana Block

CONFIDENTIAL

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612

State Board of Healing Arts

PHONE: 785-296-7413
FAX: 785-368-7103
KSBHA_healingarts@ks.gov
www.ksbha.org

Susan B Gile, Interim Executive Director

Laura Kelly, Governor

February 7, 2022

Alison Diana Block, MD

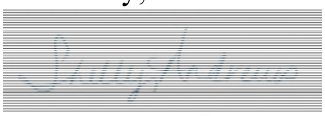
CONFIDENTIAL

Dear Alison Diana Block:

CONFIDENTIAL

CONFIDENTIAL

Sincerely,



Michelle Andrews
Licensing Analyst
Phone: 785-296-1926
Email: Michelle.Andrews@ks.gov

MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advocating high quality, safe medical care.

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

January 27, 2022

Kansas State Board of Healing Arts
800 SW Jackson
Lower Level-Suite A
Topeka, KS 66612

To Whom It May Concern:

This is to certify that as of January 27, 2022, the records of the Medical Board of California (Board) indicate the following information:

Physician:	ALISON DIANA BLOCK
License Number:	A122363
Issued Date:	August 3, 2012
Exam Type:	A Written Examination
Expiration Date:	August 31, 2022
License Status:	Current
Board Discipline and/or Administrative Action:	No

If Board Discipline and/or Administrative Action is indicated, public records may be available at http://www.mbc.ca.gov; or you may contact the Board's Enforcement Program, Central File Room by email at central.fileroom@mbc.ca.gov, by fax at (916) 263-2420 or by mail at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain information concerning the action.

Marina O'Connor
Chief of Licensing

From: support@veridoc.org
To: KSBHA_Licensing
Subject: License Verification Statement - BLOCK, ALISON
Date: Thursday, January 27, 2022 1:22:46 PM
Attachments: v965458AA.pdf

Verification of Licensure Status

The attached verification report has been sent to you by the VeriDoc.org website. This email can be verified coming from this site by clicking on the link below.

Validate Verifications

Physician: BLOCK, ALISON

Transaction ID: 965458

Confirmation Number: CONFIDENTIAL

Information from the attached verification can be refreshed for up to 6 months. To view an updated copy, click on link below.
California, Medical Board of

Kansas

ADDENDUM 4
FINGERPRINT AND BACKGROUND CHECK INSTRUCTIONS

A criminal background check is required prior to issuance of licensure. Be aware that fingerprint processing may delay your application. **Please make it a priority to complete the fingerprint process.**

Following is the Waiver Agreement and FBI Privacy Act Statement. Please complete, sign and date the top portion of this form. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without a completed and signed Waiver Agreement.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. It is not necessary that it be a law enforcement agency, however they must be authorized to do fingerprints. Please visit https://www.nbinformation.com/locations/locationMap.php for a listing of fingerprinting locations.

Fingerprints to be submitted for background checks must be recorded on the current version of the FBI's Applicant Fingerprint Card, FD Form 258. Some agencies offer electronic scanning (Livescan) please note the fingerprints must be printed on the fingerprint card and submitted to the Board. Please check with the fingerprinting agency to see if fingerprint cards are available or if a fee is required. To request a fingerprint card be mailed to you please email KSBHA_Licensing@ks.gov or call (785) 296-7413.

Complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submission. Include name, aliases, complete mailing address, social security number, citizenship, date of birth, and personal information (sex, race, height, weight, eyes, hair, place of birth). The spaces for OCA, FBI and MNU numbers can be left blank. Cards with missing or incomplete information will be rejected and must be resubmitted.

Mail the completed Waiver Agreement and fingerprint card to the Board. You may want to use a mailing service that allows for delivery confirmation.

Kansas State Board of Healing Arts
Attn: Licensing
800 SW Jackson, Lower Level – Suite A
Topeka, KS 66612
Phone: (785) 296-0934
Email: KSBHA_Licensing@ks.gov

Fingerprint results are valid for 6 months from the date received. Applications for licensure completed after the 6-month period will be required to submit a new Waiver Agreement, fingerprint card, and $47 fee.

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) **The Kansas State Board of Healing Arts** to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. The fingerprints are authorized to be submitted under the authority of the National Childcare Protection Act/Volunteers for Children Act (NCPA/VCA) explained in Public Law 103-209 and Public Law 105-251. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, the Authorized Recipient may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the above-referenced Authorized Recipient of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Authorized Recipient may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities until the criminal history background check is completed.

I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose to challenge the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. (See 5 United States Code (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C.534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).
Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other
information that may be pertinent to the application. During the processing of this application, and for as
long hereafter as may be relevant to the activity for which this application is being submitted, the FBI
may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

Routine Uses:
The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System

(Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:
The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness.

Alternatively, you may obtain a copy of your **Kansas criminal history record information** (CHRI) to review for accuracy and completeness, by submitting a set of your fingerprints, a letter requesting your criminal history record, and payment of the appropriate fee to the KBI. For further details, including the current fee, visit the following Internet website: http://www.kansas.gov/kbi/info/info_brochures.shtml then find the brochure named "Record Checks for Non-Criminal Justice Purposes". Or, to provide official court documents to make a correction you may write to:

Kansas Bureau of Investigation
Attn: Criminal History Records
1620 SW Tyler
Topeka, Kansas 66612-1837

If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license, certification or registration, or adoption.

To obtain a copy of your **national CHRI, also known as the Identity History Summary**, for review and challenge you must submit a set of your fingerprints and the appropriate fee to the FBI. Information regarding this process may be obtained at: https://www.fbi.gov/services/cjis/identity-history-summary-checks. Or, you may write to:

FBI CJIS Division
Attn: Criminal History Analysis Team 1
1000 Custer Hollow Road
Clarksburg, West Virginia 26306

UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE CHECKLIST

After completing the Uniform Application, you are responsible for submitting certain documents. There are two checklists below; one to use if you are using the Federation Credentials Verification Service (FCVS) and one to use if you are not using FCVS. Please use the checklist that applies to you.

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed Uniform Application (UA).	☐	☐
Completed state addenda and fees (Application - **$300**, National Practitioner Data Bank Report **$3**, KBI Fee **$47**) sent to the Board.	☐	☐
Notarized UA Affidavit and Authorization for Release of Information form sent to the Board.	☐	☐
Request verification of other licenses permits or certifications, if applicable. The Board will verify your credentials for any state or jurisdiction that provides free and current verifications on their official state website. If the Board is unable to verify your credentials, complete the Verification Form and forward to all licensing agencies.	☐	☐
American Medical Association or American Osteopathic Information Association report sent to the Board from the AMA or AOIA.	☐	☐
Completed Background Check Waiver, Fingerprint card, **$47** Fee.	☐	☐
Supporting documentation of any legal name change sent to the Board.	☐	Completed via FCVS
Medical Education Verification form sent to the Board from all medical schools attended.	☐	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school(s).	☐	Completed via FCVS
Medical School Diploma sent to the Board by your medical school(s).	☐	Completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended, even from those you have not completed.	☐	Completed via FCVS
Fifth Pathway form (if applicable) sent to the Board from the medical school and institution - include a copy of your diploma (must be sealed by your school).	☐	Completed via FCVS
Examination Transcripts sent to the Board.	☐	Completed via FCVS
ECFMG Status Report (if applicable) sent to the Board.	☐	Completed via FCVS

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Suite A
Topeka, KS 66612
Phone: 785-296-7413
www.ksbha.org

KANSAS
BOARD OF HEALING ARTS

KANSAS LICENSURE APPLICATION ADDENDUM INSTRUCTIONS MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY(DO)

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Addendum

Complete each addendum as instructed. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Kansas State Board of Healing Arts at the address above.

☐ **Addendum 1** — These questions must be completed by the applicant.

☐ **Addendum 2** — Each question must be completed by the applicant. Documentation must be provided for any "yes" answer(s). **It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

☐ **Addendum 3** — This form must be completed by the applicant. All applicants for licensure in the State of Kansas must request a disciplinary inquiry report from the Federation of State Medical Boards (FSMB). Once this form has been completed, you may email it to the FSMB at boardinquiry@fsmb.org.

If you are using FCVS, do not complete this form. They will obtain your disciplinary report and send it to the Board.

☐ **Addendum 4** — Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. Addendum 4 explains in detail how to obtain and submit fingerprints to the Board.

Complete, sign and date the top portion of Waiver Agreement and FBI Privacy Act Statement. At the time fingerprints are collected the fingerprinting agency must complete the bottom portion. Mail the completed form and fingerprint card to the Board. Fingerprints will not be submitted for processing without completed and signed Waiver Agreement. Submit completed background check waiver, Fingerprint card, and $47 fee.

Be aware that fingerprint processing may delay your application. Please make it a priority to complete the fingerprint process.

☐ **Credit Card Payment Authorization Form** — To pay by debit or credit card, complete the Credit Card/Debit Card Authorization Form.

Application fees must be submitted with the application. These *fees are* ***non-refundable*** and will be processed upon receipt. The Kansas Medicine and Surgery application fee is $300. Also, a background check fee of $47 and a National Practitioner Data Bank ("NPDB") report fee of $3 must accompany the application. **This totals $350.**

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

The FBI will forward your challenge to the appropriate contributing agency to verify or correct the entry. Upon receipt of an official communication directly from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (see 28 CFR 16.30 through 16.34). The Authorized Recipient must submit a new set of fingerprints and fee to receive the updated federal criminal history record.

I have ____ ***OR*** have not X been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 5903.

The name, address, and date of birth provided below appear on a valid identification document as defined in Title 28 United States Code, section 1028.

I have been provided the Waiver Agreement, FBI Privacy Act Statement, and information how to challenge my criminal records for accuracy and completeness.

Signature	1/12/22 Date
Alison D. Block	CONFIDENTIAL
Printed Name	Date of Birth

CONFIDENTIAL

Residential Address	City	State	Zip

TO BE COMPLETED BY THE FINGERPRINTING AGENCY:

Method of Verifying Identity: ☐ Driver's License ☐ State Issued ID Card ☐ Military ID Card

State/Branch: _____ ID Number: _____

Agency Name: _____

Address: _____

Telephone: _____ Fax: _____

Name of Individual Verifying Identity: _____

AUTHORIZED RECIPIENT: ***1. Must maintain original or arrange for KBI to maintain.***
2. Must provide a copy to the applicant.

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose to challenge the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. (See 5 United States Code (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C.534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).
Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other
information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

Routine Uses:
The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System

(Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:
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Topeka, Kansas 66612-1837

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FBI CJIS Division
Attn: Criminal History Analysis Team 1
1000 Custer Hollow Road
Clarksburg, West Virginia 26306