KENTUCKY APPLIED BEHAVIOR ANALYST LICENSING BOARD

P.O. Box 1360, Frankfort, Kentucky 40602
911 Leawood Drive, Frankfort, Kentucky 40601 (Overnight Delivery Only)
Phone: (502) 564-3296 ~ Fax: (502) 696-4961 ~ http://dop.ky.gov

APPLICATION FOR LICENSURE

INSTRUCTIONS

1. This application shall be typed or printed legibly and completed in its entirety.
2. This application and all supporting material shall be submitted to the Kentucky Applied Behavior Analyst Licensing Board.
3. Attach continuation sheets if more space is needed to provide information.
4. This application and all supporting material shall be submitted with the required fee as shown in fee schedule. This fee is nonrefundable. All fees paid by check or money order shall be made payable to the **Kentucky State Treasurer**. DO NOT SEND CASH.
5. Refer to KRS 319C.060 (2), and 201 KAR 43:010, 43:020, and 43:030.
6. This completed notification may be submitted to the Kentucky Applied Behavior Analyst Licensing Board either by mail to P.O. Box 1360, Frankfort, KY 40602 or by overnight delivery to 911 Leawood Drive, Frankfort, Kentucky 40601.

APPLICATION TYPE

☐ Licensed Behavior Analyst (LBA)-Application Review Fee $100.00; Licensure Fee $300.00
☐ Licensed Assistant Behavior Analyst (LaBA)-Application Review Fee $ 100.00; Licensure Fee $ 200.00
☐ Temporary Licensed Behavior Analyst (TLBA)-Application Review Fee $ 100.00; Temporary Licensure Fee $ 200.00
☐ Temporary Licensed Assistant Behavior Analyst (TLaBA)-Application Review Fee $100.00; Temporary licensure Fee $100.00

APPLICATION INFORMATION

1. ____

Name: Last | First | Middle Initial | Social Security Number

____

Mailing Address: Street | City | State | Zip Code

(   )   -   (   )   -   (   )   -

Home Phone Number | Work Phone Number | Mobile Phone Number | Email Address

Are you a U.S. Citizen? ☐ Yes ☐ No   Gender: ____________   Date of Birth: ____________

2. BACB Certification Number: ____________   Date of Initial BACB Certification: ____________
   BACB Certification status: ☐ Active ☐ Inactive

3. Are you licensed as a health care provider in Kentucky, or in any other jurisdiction? ☐ Yes ☐ No
   If yes, Please indicate the jurisdiction in which you are currently licensed: ____________________

4. Has your license or certification in Kentucky or any other state ever been disciplined or revoked? ☐ Yes ☐ No
   If yes, please give details on a separate sheet listing the date and governing body that suspended or revoked your license or certification and the exact reason for the suspension or loss.

5. Have you ever been convicted of a felony? ☐ Yes ☐ No
   If yes, please attach an explanation and official court documentation showing disposition of the case.

6. Have you ever been discharged or forced to resign for misconduct from any position, from any professional training program, or from the program of any university? ☐ Yes ☐ No
   If yes, please attach explanation and supporting documentation.

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7. Have you reviewed the Laws and Regulations Relating to Licensure as an Applied Behavior Analyst (KRS Chapter 319 and 201 KAR Chapter 43 - available at http://www.aba.ky.gov) ☐ Yes ☐ No

8. Have you completed the required 5 hours of training in abuse, neglect, and exploitation? ☐ Yes ☐ No

9. Population Focus/Specialty: ______________________________

10. How many clinical jobs do you have (or plan to have)? ________
    a. Practice setting (primary): ______________________________
    b. Practice setting (secondary): ______________________________
    c. Practice location(s): ______________________________

11. Approximate number of clients to be served per week, direct ________
    Approximate number of clients to be served per week, indirect ________

12. If you are applying for a temporary or assistant license, please indicate who will be supervising your practice. You will also need to submit an Annual Supervisory Plan for board approval.

____
Supervisor Name   Certification Number

____
Supervisor Name   Certification Number

APPLICANT'S AFFIDAVIT

I, the applicant named in the above, do hereby certify under penalty of law that the information contained herein is true, correct, and complete to the best of my knowledge and belief.
I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my license/certification revoked by the board.

______________________________   ______________________________
Applicant's Signature   Date

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PLEASE COMPLETE THE FOLLOWING RELATED TO YOUR STATUS
(Shall be submitted with application materials)

1. Have you been denied licensure/certification in any state or jurisdiction? ☐ Yes ☐ No
2. Has your license/certification been suspended or revoked in any state or jurisdiction? ☐ Yes ☐ No
3. Have you surrendered or allowed your license/certification to lapse in any state or other jurisdiction due to an action pending or threatened? ☐ Yes ☐ No
4. Has your license or certification been subject to any disciplinary action by any licensure/ regulatory board? ☐ Yes ☐ No
5. Have you entered into a consent agreement or other arrangement with any licensure or regulatory board in connection with a disciplinary action? ☐ Yes ☐ No
6. Are you aware of any pending disciplinary action against your license or certification in any state or other jurisdiction? ☐ Yes ☐ No
7. Have your clinical privileges at any hospital or other health care institution or clinic been denied, limited, suspended, revoked, or not renewed for any reason? ☐ Yes ☐ No
8. Have you been denied professional liability insurance or has your policy been cancelled and / or restricted? ☐ Yes ☐ No
9. Have you had psychiatric hospitalization in the past five years? ☐ Yes ☐ No
10. Have you been treated for alcohol or drug abuse / dependence in the past five years? ☐ Yes ☐ No
11. Do you suffer from any illness or health condition that limits or impairs your ability to practice in your profession? ☐ Yes ☐ No
12. Have you ever been convicted of a felony? ☐ Yes ☐ No
13. Has any third party payer, including Medicare or Medicaid, terminated, suspended, restricted or revoked your status as a provider for reasons related to the quality of your professional practice? ☐ Yes ☐ No
14. Have you been disciplined by a professional organization for a violation of ethical standards? ☐ Yes ☐ No
15. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank? ☐ Yes ☐ No

If you have answered "yes" to any of the above questions, please explain on a supplementary sheet.

I do hereby certify under penalty of law that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my license/certification revoked by the board.

______________________________ ______________________________
Applicant's Signature Date