



KENTUCKY APPLIED BEHAVIOR ANALYSIS LICENSING BOARD

P.O. Box 1360, Frankfort, Kentucky 40602
500 Mero St. 2SC 32, Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 892-4249

Fax: (502) 564-4818

<http://aba.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 Analysis 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 Analysis Licensing Board either by mail to P.O. Box 1360, Frankfort, KY 40602 or by overnight delivery to 500 Mero St. 2SC 32, 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	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? <input type="checkbox"/> Yes <input type="checkbox"/> No Gender: _____			Date of Birth: _____



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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. ~~Have you reviewed the Laws and Regulations Relating to Licensure as an Applied Behavior Analyst? (KRS Chapter 319c and 201 KAR Chapter 43 - available at <http://aba.ky.gov>) Yes No~~ ~~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 completed the required 5 hours of training in abuse, neglect, and exploitation? Yes No~~ ~~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. ~~Population Focus/Specialty: [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.]~~

7. How many clinical jobs do you have (or plan to have)? _____

a. Practice setting (primary): _____

c. Practice location(s): _____ [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]

9. Have you been denied licensure/certification in any state or jurisdiction? Yes No [Population Focus/Specialty:]

10. Has your license/certification been suspended or revoked in any state or jurisdiction? Yes No [How many clinical jobs do you have (or plan to have)? a. Practice setting (primary): b. Practice setting (secondary): c. Practice location(s):]

11. Have you surrendered or allowed your license/certification to lapse in any state or other jurisdiction due to an action pending or threatened? Yes



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No [Approximate number of clients to be served per week, direct
Approximate number of clients to be served per week, indirect]

12. Has your license/certification been subject to any disciplinary action by any licensure regulatory board? Yes No [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]

13. Have you entered into a consent agreement or other arrangement with any licensure regulatory board in connection with a disciplinary action? Yes No

14. Are you aware of any pending disciplinary action against your license/certification in any state or other jurisdiction? Yes No

15. 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

16. Have you been denied professional liability insurance or has your policy been cancelled or restricted? Yes No

17. Have you had psychiatric hospitalization in the past five years? Yes No

18. Have you been treated for alcohol or drug abuse/dependence in the past five years? Yes No

19. Do you suffer from any illness or health condition that limits or impairs your ability to practice in your profession? Yes No

20. Have you ever been convicted of a felony? Yes No

21. 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

22. Have you been disciplined by a professional organization for a violation of ethical standards? Yes No

23. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank? Yes No

24. Do you meet all educational, examination, and credentialing requirements established in KRS 319C.080 (1)? If yes, please attach proof and list VCS number. <https://www.abainternational.org> Yes No

Temporary Licensing Questions



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25. If 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: _____

26. If applying for a temporary license, are you aware that the temporary license will expire four (4) years from the date of issuance and cannot be renewed? Yes No

27. If applying for a temporary license, did you complete your coursework through a BACB or ABAI Verified Course Sequence? Yes No

If yes, attach an official copy of your post-secondary transcript attached. (<https://www.abainternational.org>)

If no, go to Question 28.

28. If applying for a temporary license, did you complete your coursework from a non-BACB or non-ABAI Verified Course Sequence? Yes No

If yes, attach an official copy of your post-secondary transcript and course syllabi for all behavior-analytic course work. _____

[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 denied~~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. ~~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~~
3. ~~Has your license or certification been subject to any disciplinary action by any licensure/regulatory board? Yes No~~
4. ~~Have you entered into a consent agreement or other arrangement with any licensure or regulatory board in connection with a disciplinary action? Yes No~~
5. ~~Are you aware of any pending disciplinary action against your license or certification in any state or other jurisdiction? Yes No~~
6. ~~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~~
7. ~~Have you been denied professional liability insurance or has your policy been cancelled and / or restricted? Yes No~~
8. ~~Have you had psychiatric hospitalization in the past five years? Yes No~~
9. ~~Have you been treated for alcohol or drug abuse / dependence in the past five years? Yes No~~
10. ~~Do you suffer from any illness or health condition that limits or impairs your ability to practice in your profession? Yes No~~
11. ~~Have you ever been convicted of a felony? Yes No~~
12. ~~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~~
13. ~~Have you been disciplined by a professional organization for a violation of ethical standards? Yes No~~
14. ~~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]