KENTUCKY APPLIED BEHAVIOR ANALYSIS LICENSING BOARD

P.O. Box 1360, Frankfort, Kentucky 40601
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~~] RENEWAL OR REINSTATEMENT

Instructions

1. This application shall be typed or printed legibly and completed in its entirety[~~In accordance with 201 KAR 43:080 your renewal for Licensed Behavior Analyst or Licensed Assistant Behavior Analyst shall biennially be submitted on or before the last day of the calendar month during which the license was issued~~].
2. This application and all supporting material shall[~~must~~] 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 the 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) [~~Renewal~~] Renewal Fee: $300
☐ Licensed Assistant Behavior Analyst (LaBA) [~~Renewal~~] Renewal Fee: $200

☐ License Reinstatement
(Less than thirty (30) days after renewal date)
License Expiration Date: _____
Renewal Fee: $300
Reinstatement Fee: $50

☐ License Reinstatement
(More than thirty (30) days after renewal date)
License Expiration Date: _____
Renewal Fee: $300
Reinstatement Fee: $250

☐ License Reinstatement
(Approved inactive status)
Inactive Status Date: _____
Renewal Fee: $200

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 US citizen? ☐ Yes ☐ No Gender: _____ Date of Birth: _____

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Would you like the following information to be included in the Online Active License Directory? ☐ Yes ☐ No

Business Mailing Address Street City State Zip Code

Business Phone Number Business Email

2. BACB Certification: _____ Date of Initial BACB Certification: _____
BACB Certification Status: ☐ Active ☐ Inactive

3. Are you licensed as a health care provider in Kentucky or any other jurisdiction? ☐ Yes ☐ No

If yes, please indicate the jurisdiction in which you are currently licensed: _____

4. Were you employed during the time of inactive or expired status? ☐ Yes ☐ No
If yes, please attach an explanation and supporting documents [~~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. Did you comply with the BCBA certification requirements during the period in which you did not practice?
If yes, please provide documentation ☐ 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. Have you reviewed the Laws and Regulations Relating to Licensure as an Applied Behavior Analyst? (KRS 319c and 201 KAR 43 – available at (http://aba.ky.gov) ☐ Yes ☐ No[~~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. Population Focus/Specialty: [~~Have you reviewed the Laws and Regulations Relating to Licensure as an Applied Behavior Analyst (KRS 319 and 201 KAR 43 – available at http://www.aba.ky.gov) Yes No~~]

8. How many clinical jobs do you plan to have? _____

a. Practice setting (primary): _____

b. Practice setting (secondary): _____

c. Practice location(s): _____

[~~Population Focus/Speciality:~~]

9. Approximate number of clients to be served per week, direct _____

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Approximate number of clients to be served per week, indirect _____ [~~How many clinical jobs do you have (or plan to have)? a. Practice setting (primary): b. Practice setting (secondary): c. Practice location(s):~~]

10. If you are applying for reinstatement of an assistant or temporary license, please indicate who will be supervising your practice.

_____ _____
Supervisor Name Certification Number

_____ _____
Supervisor Name Certification Number[~~Approximate number of clients to be served per week, direct Approximate number of clients to be served per week, indirect~~]

11. Have you been denied licensure/certification in any state or jurisdiction? ☐ Yes ☐ No [~~If you are applying for renewal of an assistant license, please indicate who will be supervising your practice Supervisor Name Certification Number Supervisor Name Certification Number~~]

12. Has your license/certification been suspended or revoked in any state or jurisdiction? ☐ Yes ☐ No

13. 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

14. Has your license/certification been subject to any disciplinary action by any licensure regulatory board? ☐ Yes ☐ No

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

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

17. 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

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

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19. Have you had psychiatric hospitalization within the past five years? ☐ Yes ☐ No

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

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

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

23. 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

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

25. 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.

[~~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~~
~~(Must 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~~]