

## INSTRUCTIONS FOR LICENSURE APPLICATION THROUGH RECIPROCITY (LCAC)

1. Before you begin to complete the application form, please read all instructions and review the statutes and regulations so that you will understand exactly what information is being requested. The statutes and regulations can be found on our website, [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov). **You must hold an active license in another state to apply for licensure through reciprocity.**
2. This application is for the Licensed Clinical Addiction Counselor (LCAC). This is a clinical level of licensure and does allow for the diagnosis of substance use disorders independently. Please review the statutes and regulations for a detailed explanation of the levels of licensure as well as requirements for licensure. If you do not meet the requirements for LCAC and wish to be licensed at the lower level (LAC), which does not allow for the diagnosis of substance use disorders, please download and complete the Application through Reciprocity for LAC.
3. Answer all questions on the application completely and accurately. The burden of proof in satisfying to the Board that you are eligible for licensure is upon you.
4. **Fee:** Instructions for paying the \$50.00 application fee may be found on **Appendix A. FEES ARE NON-REFUNDABLE.**
5. As part of the application process, you are required send **Attachment A = Out-Of-State Clearance form** to each of the licensing boards or jurisdictions you hold, or have held, a professional license, certificate, or registration. The licensing agency should complete the form and return it directly to the Board office.
6. **Routes for Reciprocity**

**Route 1)** Standards of your state's requirements are substantially equivalent to Kansas requirements for licensure as a clinical addiction counselor. See KSA 65-6607 through 65-6620 and as amended in L. 2011, ch.114 beginning with Sec.10. Detailed requirements may be found in the regulations. All statutes and regulations can be found on our website.

**Route 2) A.** Continuous Registration, certification or licensure with a similar scope of practice for at least 12 months immediately preceding the date of application for reciprocity with Kansas.

**B.** Absence of disciplinary action of a serious nature brought by a registration, certification or licensing Board. This will be attested to on Attachment A and should be completed by your licensing agency.

**C.** At least a masters degree.

**D.** In addition to the requirements listed in #6 after meeting route 1 or 2, you must also demonstrate the ability to diagnosis and treat substance use disorders through at least two of the following areas acceptable to the board:

1. **(i)** Satisfactory completion of 15 graduate credit hours supporting diagnosis and treatment of substance use disorders which includes: three graduate semester hours of discrete coursework in ethics, three graduate semester hours of discrete coursework in the diagnosis and treatment of substance use disorders that includes studies of the established diagnostic criteria for substance use disorders, and coursework that addresses interdisciplinary referrals, interdisciplinary collaborations, and treatment approaches; **OR**  
**(ii)** Passing a national Examination for clinical addiction counseling.

2. One or both of the following types of documentation which will need to cover a period of at least 3 years;  
- Use Attachment B.

**(i)** An attestation by a supervisor or other designated representative of your employer that you have had at least 3 years of clinical practice, including at least 8 hours of client contact per week during 9 months or more of each year in a treatment facility, community mental health center or its affiliate, state mental hospital, or another employment setting in which the applicant engaged in clinical practice that included diagnosis or treatment of substance use disorders; **OR**

**(ii)** an attestation by the applicant that the applicant engaged in at least three years of independent clinical practice that included diagnosis or treatment of substance use disorders, as well as supporting documentation, please see Attachment B for a list of appropriate documentation.

3. An attestation that the applicant has demonstrated competence in diagnosis or treatment of substance use disorders, which shall be signed by either a professional licensed to practice medicine and surgery or another professional licensed to diagnose and treat mental disorders or substance use disorders, or both, in independent practice. – Use Attachment C.

Allow 30 days for review of your application. Please **check the status of your application on our website [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov)**, under “Applicants.”

## Application Checklist

**When you submit your application to the Board office the following items should be included:**

**All applicants must submit the following:**

- The application fee of \$50.00; See Appendix A
- The completed application form;
- Appropriate attachments showing competence to diagnosis and treat substance use disorders;

**These additional items need to be sent directly to the Board office by the appropriate institutions:**

- Attachment A = Out-of-State Clearance form, submitted directly by any state or jurisdiction which you hold or have held a license, registration, or certification;
- Transcript, if your licensing board will not provide your education information.

*The Board office will contact you by mail, email, or phone regarding the status of your application. Be sure the Board office has current contact information on file for you. It is the applicant's responsibility to notify the Board in writing of any name or address change that might occur during the application process.*

Behavioral Sciences Regulatory Board  
700 SW Harrison St. Suite 420  
Topeka, KS 66603-3929



Phone: 785-296-3240  
Fax: 785-296-3112  
[www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov)

David B. Fye, JD, Executive Director

Laura Kelly, Governor

## LICENSURE APPLICATION THROUGH RECIPROCITY (LCAC)

**Application Fee: \$50.00 please see Appendix A**

This application is only for applicants who are licensed, registered, or certified in another state to practice clinical addiction counseling and are applying under the reciprocity statute.

### I. Identifying information: (Please type or print clearly in ink)

Legal Name: \_\_\_\_\_  
Last First Middle

Maiden/Other names used: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ (Note: Your social security number is required pursuant to 42 U.S.C.S. § 666(a)(13), K.S.A. 74-148 and K.S.A. 74-139, and may be used for child support enforcement purposes or provided to the Kansas director of taxation upon request.)

Preferred E-Mail Address: \_\_\_\_\_ Preferred Mailing: Home \_\_\_\_\_ Business \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone (optional): \_\_\_\_\_

Home Address: \_\_\_\_\_ Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_ Suite Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_

- A. Are you a military servicemember (a current member of any branch of the United States armed services, United States military reserves or national guard of any state, or a former member with an honorable discharge) Yes \_\_\_\_\_ No \_\_\_\_\_  
(If yes, please provide a copy of your military ID, a copy of your DD-214, or other proof of military service.)
- B. Are you a military spouse (the spouse of a military servicemember)? Yes \_\_\_\_\_ No \_\_\_\_\_  
(If yes, please provide a copy of your military ID, DD-214, or other proof of military service.)
- C. Have you established residency in the State of Kansas? Yes \_\_\_\_\_ No \_\_\_\_\_
- D. If no, do you intend to establish residency in the State Kansas? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "Yes" please explain:  
\_\_\_\_\_

### II. Information on Previous Licensure:

- A. Do you currently hold a certificate, registration or license to practice in addiction counseling in another state or jurisdiction? Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes", please answer the following questions:

- Under what name: \_\_\_\_\_
- For which state: \_\_\_\_\_ License Number: \_\_\_\_\_
- For which credential: \_\_\_\_\_ Is this a clinical level? Yes \_\_\_\_\_ No \_\_\_\_\_
- Does this credential allow you to practice independently, including the diagnosis and treatment of substance use disorders? Yes \_\_\_\_\_ No \_\_\_\_\_
- Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
- Was this continuous licensure? Yes \_\_\_\_\_ No \_\_\_\_\_

7. If no, what period of time where you NOT licensed: \_\_\_\_\_

B. Have you ever filed any application for licensure or registration in Kansas? Yes \_\_\_ No \_\_\_  
If "yes", please answer the following questions:

1. Under what name: \_\_\_\_\_

2. When: \_\_\_\_\_ For which credential: \_\_\_\_\_

**We must receive an Out-Of-State Clearance form from all states in which you hold or have held a license, registration, or certification. This is not limited to clinical addiction counseling.**

### III. Merit of the Public Trust:

A. If you answer yes to question 1 and/or 2, regarding convictions, you are required to complete the Conviction Packet. Click on this link to download [Conviction Packet](#) or you may find this packet on our website, [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov) under forms. See # 2 in the instructions.

1. Have you ever been convicted of a felony? Yes \_\_\_ No \_\_\_  
2. Have you ever been convicted of a misdemeanor crime against a person? Yes \_\_\_ No \_\_\_

B. If you answer "Yes" to any of the following questions, **you are required to submit as part of your application a signed, dated, type-written explanation that gives specific details including disposition of the matter.**

*Your application will not be processed without this information.*

3. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds? Yes \_\_\_ No \_\_\_  
4. Have you used any alcohol, narcotic, barbiturate other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years? Yes \_\_\_ No \_\_\_  
5. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years? Yes \_\_\_ No \_\_\_  
6. Have you used controlled substances which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years? Yes \_\_\_ No \_\_\_  
7. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes \_\_\_ No \_\_\_  
8. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit? Yes \_\_\_ No \_\_\_  
9. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult? Yes \_\_\_ No \_\_\_

### IV. Educational Qualifications:

#### A. Transcript(s):

All transcripts must be sent directly from your college or university or licensing agency to the Board office. The Board cannot accept any transcripts received from the applicant.

**Route 1)** You are required to provide verification of your degree. This may be verified by the licensing agency in your state or jurisdiction on the Out-Of-State Clearance form. However, if the licensing agency will not provide this information you are required to have an official transcript(s) submitted to the Board office.

**Route 2)** If your degree is in addiction counseling you are required to provide verification of your degree This may be verified by the licensing agency in your state or jurisdiction on the Out-Of-State Clearance form. However, if the licensing agency will not provide this information you are required to have an official transcript(s) submitted to the Board office; or

If your degree is in a related field you are required to have an official transcript(s) submitted to the Board office. This will be used to verify your degree as well as the required coursework.

**B.** List all colleges or universities you have attended and at what level:

INSTITUTION	DATES OF ATTENDANCE From - To	MAJOR/AREA OF CONCENTRATION	DEGREE RECEIVED	DATE DEGREE CONFERRED

**C.** Give other name(s) under which your coursework was taken or your degree was conferred, if different from the name you use now:

\_\_\_\_\_

**V. Examination or Coursework, if you are using passage of an approved examination OR the 15 hours of graduate coursework to show competence to diagnose and treat substance use disorders, please complete the appropriate section below.**

**Examination:**

Did you complete a national Examination for clinical addiction counseling? Yes \_\_\_ No \_\_\_

**If you answered "yes" please answer the following:**

1. Name of examination: \_\_\_\_\_ Who Administers the examination: \_\_\_\_\_
2. What level of examination did you complete: \_\_\_\_\_
3. Through what state or jurisdiction: \_\_\_\_\_ Date exam was taken: \_\_\_\_\_
4. Did you pass in your jurisdiction? Yes \_\_\_ No \_\_\_ Score Received: \_\_\_\_\_

**Be sure to** request verification of your passing score on Attachment A or scores may be sent to the Board office directly from the examination service.

**15 Graduate Hours for Clinical Licensure**

If you are using the coursework option, you must show completion of at least 15 graduate credit hours supporting the diagnosis and treatment of substance use disorders, which shall include the following:

- Three graduate semester hours of discrete coursework in ethics;
- three graduate semester hours of discrete coursework in the diagnosis and treatment of substance use disorders that includes studies of the established diagnostic criteria for substance use disorders; and
- coursework that addresses interdisciplinary referrals, interdisciplinary collaborations, and treatment approaches.

Course #	Course Title	Credit Hrs	University/College
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**VIII. Applicant's Attestation:**

- A. I have reviewed the licensure eligibility requirements prior to submitting this application. Yes\_\_\_ No\_\_\_
- B. I have completed the application materials and procedures honestly and in good faith. Yes\_\_\_ No\_\_\_
- C. I understand that the members and staff of BSRB are compelled by law to uphold, implement and enforce the licensure statutes and regulations as written. Yes\_\_\_ No\_\_\_
- D. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but any such research will not personally identify the applicants or licensees, either directly or indirectly. Yes\_\_\_ No\_\_\_
- E. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a BSRB form required for licensure or licensure renewal. Yes\_\_\_ No\_\_\_
- F. I **have read** and am familiar with the appropriate statutes and regulations governing the practice of the professional license for which I am applying. Yes\_\_\_ No\_\_\_
- G. I understand that **once the Board receives my application I am bound by, and will abide by, the statutes and regulations** governing the profession of the license for which I am applying Yes\_\_\_ No\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPLICATION FOR LICENSURE THROUGH RECIPROCITY**

***Attachment A - Out-of-State Clearance Form***

**Instructions:**

Section 1 is to be completed by the applicant and sent to the state or jurisdiction in which a license, registration, or certification is held or has been held. Additional copies of this form may be made and used as needed by the applicant. Section 2 is to be completed by a representative of your licensing board and returned directly to the Behavioral Sciences Regulatory Board.

**I. SECTION 1: This section is to be completed by the applicant:**

- A. Name: \_\_\_\_\_
- B. Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
- C. Maiden or other name in which license was issued: \_\_\_\_\_
- D. Type of Credential held in the other state: \_\_\_\_\_
- E. Type or Field of Practice: \_\_\_\_\_
- F. License Number: \_\_\_\_\_
- G. Date of Issuance: \_\_\_\_\_
- H. Date of Expiration: \_\_\_\_\_
- I. Level of Licensure (Baccalaureate, Masters, Doctorate): \_\_\_\_\_
- J. Current licensing requirements to be submitted with out of state clearance form ? **Yes** \_\_\_\_ **No** \_\_\_\_  
*If you are applying for licensure through "substantially equivalent" licensing requirements, your current licensing agency will need to provide current licensing requirements with this form.*

**II. SECTION 2: This section is to be completed by the State Board. Upon completion, please return this form to: BSRB, 700 SW Harrison St., Ste. 420, Topeka, KS 66603-3929.**

- A. Type of Credential (please circle applicable designation): Licensure \_\_\_\_ Registration \_\_\_\_ Certification \_\_\_\_
- B. Type or Field of Practice: \_\_\_\_\_
- C. Lic/Reg/Cert Title: \_\_\_\_\_ Lic/Reg/Cert Number: \_\_\_\_\_
- D. Date Issued: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_
- E. Did license ever lapse or expire prior to date of expiration listed in letter "D"? **Yes** \_\_\_\_ **No** \_\_\_\_  
If yes, please explain: \_\_\_\_\_
- F. Level of Lic/Reg/Cert (Baccalaureate, Masters, Doctorate): \_\_\_\_\_
- G. Does this license allow independent practice including the diagnosis and treatment of substance use disorders? **Yes** \_\_\_\_ **No** \_\_\_\_
- H. Is Lic/Reg/Cert in Good Standing? **Yes** \_\_\_\_ **No** \_\_\_\_ If "no", please state reason(s):  
\_\_\_\_\_  
\_\_\_\_\_

I. Has the Lic/Reg/Cert ever been suspended or revoked? **Yes** \_\_\_ **No** \_\_\_ If **"yes"**, please state reason(s):

\_\_\_\_\_  
\_\_\_\_\_

J. Has the Lic/Reg/Cert ever been surrendered voluntarily in lieu of an investigation? **Yes** \_\_\_ **No** \_\_\_  
If **"yes"**, please explain:

\_\_\_\_\_  
\_\_\_\_\_

K. Degree Received: \_\_\_\_\_ Major: \_\_\_\_\_

Date Degree Received: \_\_\_\_\_

L. University or Institution of where degree was completed: \_\_\_\_\_

M. Current licensing requirements are attached with this form? **Yes** \_\_\_ **No** \_\_\_

N. Examination Information:

Name of examination taken? \_\_\_\_\_

Who Administered the examination? \_\_\_\_\_

What level of examination did the licensee complete? \_\_\_\_\_

Through what state or jurisdiction: \_\_\_\_\_ Date exam was taken: \_\_\_\_\_

Required score to pass: \_\_\_\_\_ Score Received: \_\_\_\_\_ Passed? **Yes** \_\_\_ **No** \_\_\_

N. Additional Comments:

Signature of State Board Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Official Title/Position: \_\_\_\_\_

State or Jurisdiction: \_\_\_\_\_

Agency: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_



***APPLICATION FOR LICENSURE THROUGH RECIPROCITY***

***Attachment B - ATTESTATION OF CLINICAL EXPERIENCE ATTACHMENT***

Applicant Name \_\_\_\_\_

If you were in an independent practice setting when you completed the required three years of clinical experience, please complete Section A and attach appropriate documentation, as listed below and return the form with your application for licensure.

If you were an employee when you completed the required three years of clinical experience, please skip section A and have your work supervisor complete section B. The supervisor should return the completed form in a sealed envelope with their signature across the seal. You will then submit the form in the unopened envelope with the rest of your application.

**A. Independent Practice:** If you worked in an independent practice setting, please complete the following:

Name of Agency \_\_\_\_\_ Phone \_\_\_\_\_

Address of Agency \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I \_\_\_\_\_, attest that I have engaged in a minimum of 3 years of independent clinical practice which included diagnosis and treatment of mental disorders.

**Please attach one of the following forms of documentation before submitting form to the Kansas BSRB:**

- Published job description,
- Description of your practice in a public information brochure,
- Description of services in an informed consent document, or
- A similar published statement demonstrating you have engaged in independent clinical practice for a minimum of 3 years **OR**
- An attestation signed by a professional licensed to practice medicine and surgery, or a licensed psychologist, a licensed specialist clinical social worker, or a professional licensed to diagnosis and treat mental disorders in independent practice.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Applicant \_\_\_\_\_

**B. Instructions for Supervisor:** Please complete only section B and return to the applicant in a sealed envelope with your signature across the seal.

Name of Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_  
Street City State Zip

Employer Phone \_\_\_\_\_ Employer Fax \_\_\_\_\_

Applicant's Position/Title \_\_\_\_\_ Applicant's Lic/Reg/Cert Type \_\_\_\_\_

Applicant's Work Dates \_\_\_\_\_  
Start Date End Date

**Continued**

Does the applicant have at least 3 years of clinical practice that included diagnosis and treatment of mental disorders?  
**Yes** \_\_\_\_ **No** \_\_\_\_

**If yes**, did the applicant conduct at least 8 hours of client contact per week for 9 months or more of each year?  
**Yes** \_\_\_\_ **No** \_\_\_\_

**If no**, how many client contact hours completed per week, per year? \_\_\_\_\_

Work Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supervisor's Lic/Reg/Cert: Type: \_\_\_\_\_ Number: \_\_\_\_\_

I have been personally acquainted with the applicant **for** \_\_\_\_\_ **years**.

I attest that the applicant \_\_\_\_\_ **is** \_\_\_\_\_ **is not** competent in diagnosis and treatment of mental disorders.

I attest that the foregoing information supplied by the applicant is true to the best of my knowledge I believe the applicant to be of good professional character and worthy of confidence.

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Supervisor: \_\_\_\_\_

**Please place this form in a sealed envelope, sign across the closed seal and return to the applicant.**



***APPLICATION FOR LICENSURE THROUGH RECIPROCITY***  
***Attachment C - ATTESTATION FROM A LICENSED PROFESSIONAL***

**Instructions to Applicant:** This form should be completed by a professional licensed to diagnose and treat mental disorders or substance use disorders, or both, in independent practice. The referencing individual should return the completed form to you in a sealed envelope with their signature across the seal. You will then submit the form in the unopened envelope with the rest of your application.

Name of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions to Referencing Individual Completing the Form:** The above named individual is applying for licensure in the State of Kansas. Please provide a written response attesting to this individual's competency to diagnose and treat substance use disorders. Return the completed form to the applicant in a sealed envelope with your signature across the seal.

A. Name of Referencing Individual: \_\_\_\_\_ Title: \_\_\_\_\_

B. License Type: \_\_\_\_\_ License Number: \_\_\_\_\_

C. Business Name: \_\_\_\_\_ Phone: \_\_\_\_\_

D. Business Address: \_\_\_\_\_  
Street Address City State Zip

E. Are you related by blood or marriage to the applicant? Yes \_\_\_ No \_\_\_  
**If yes**, state relationship: \_\_\_\_\_

F. How long have you known the applicant: \_\_\_\_\_

G. In what work setting have you known the applicant, include name of agency: \_\_\_\_\_  
\_\_\_\_\_

H. What relationship (such as supervisor or co-worker) have you had with the applicant which has aided you in forming your opinion of his/her competence to diagnose or treat substance use disorders: \_\_\_\_\_  
\_\_\_\_\_

I. Are you aware of any significant facts concerning the applicant's background which would reflect unfavorably on the applicant's character and fitness to practice as a clinical addiction counselor? Yes \_\_\_ No \_\_\_  
**If yes**, please state these facts as fully as possible on a separate sheet of paper.

J. In your opinion is the applicant competent to diagnose or treat substance use disorders? Yes \_\_\_ No \_\_\_

K. What evidence can you provide related to the applicant's competence to diagnose and treat substance use disorders? Include amount and length of experience. (Feel free to expand on a separate sheet of paper if needed).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reference's Attestation:** I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining the applicant's competence to diagnose and treat substance use disorders in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable

Reference's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return form back to applicant in a sealed envelope with your signature across the seal.**

## *Appendix A*

### *Payment Instructions*

**1.** Individuals wishing to submit payments to the BSRB using a credit card or electronic check should:

- (1) visit the BSRB website at [ksbsrb.ks.gov](http://ksbsrb.ks.gov)
- (2) select the “SERVICES” drop-down tab from the top of the home screen, and
- (3) click on the “Make A Payment” link. From this page, you will be asked to provide information allowing us to identify the applicant, select the item you wish to pay for, and make a payment for that item.

For use of the secure payment platform, the state of Kansas charges a 2.5 percent processing fee for credit card payments or a \$1.50 flat fee for use of an electronic check. After completing payment, you will receive a confirmation e-mail to confirm your payment.

Please submit payment upon mailing your application if you are using the online payment portal.

**2.** Individuals wishing to submit payment to the BSRB office by mail using a check, cash, or a money order may send the payment with their application to the Behavioral Sciences Regulatory Board, 700 SW Harrison St., Ste. 420, Topeka, KS 66603.