



APPLICATION FOR A LICENSE TO PRACTICE AS A GENETIC COUNSELOR

State Form 54121 (R / 6-10)

Approved by State Board of Accounts, 2010

**MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

* Your Social Security number is being requested by this state agency in accordance with Indiana Code. Disclosure is mandatory and this record cannot be processed without it.

** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY

Application fee	Date fee paid (month, day, year)	Receipt number	License number	License issuance date (month, day, year)
Temporary fee	Date fee paid (month, day, year)	Receipt number	Temporary license number	License issuance date (month, day, year)

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (last, first, middle)			Social Security number *	
Other names used			Date of birth (month, day, year)	
Place of birth (city, state or foreign country)	Ethnicity **	Race **	Gender ** <input type="checkbox"/> Male <input type="checkbox"/> Female	
Mailing address (number and street or rural route, city, state, and ZIP code)				
Telephone number ()	Facsimile number ()	E-mail address (Required to receive status updates on your application.)		

APPLICANT INFORMATION

Do you desire a temporary permit? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of scheduled examination (month, day, year)
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EDUCATION (Attach a separate sheet, if necessary.)

Undergraduate Education

Name of college or university	Dates attended (month, day, year)	Date of graduation (month, day, year)
Address (number and street, city, state, and ZIP code)		Degree

Graduate Education

Name of college or university	Dates attended (month, day, year)	Date of graduation (month, day, year)
Address (number and street, city, state, and ZIP code)		Degree

Other Professional Education

Name of college or university	Dates attended (month, day, year)	Date of graduation (month, day, year)
Address (number and street, city, state, and ZIP code)		Degree

EMPLOYMENT HISTORY

Please list all previous experience as a genetic counselor for the last five (5) years or since graduation from a professional program, including military or government service, listing the most recent first. Please provide a written explanation for any gaps of six (6) months or more in employment history. Attach a separate list, if necessary.

Name of employer		Dates employed (month, year to month, year)		
Location (city, state, and ZIP code)		Job title		
Name of contact person		Telephone number ()		
Name of employer		Dates employed (month, year to month, year)		
Location (city, state, and ZIP code)		Job title		
Name of contact person		Telephone number ()		
Name of employer		Dates employed (month, year to month, year)		
Location (city, state, and ZIP code)		Job title		
Name of contact person		Telephone number ()		
Name of employer		Dates employed (month, year to month, year)		
Location (city, state, and ZIP code)		Job title		
Name of contact person		Telephone number ()		

CERTIFICATION EXAMINATION

Certifying body (check one) <input type="checkbox"/> American Board of Genetic Counseling (ABGC) <input type="checkbox"/> American College of Medical Genetics (ACMG)	Date passed examination (month, year)
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BOARD CERTIFICATION

Type of certification (check one) <input type="checkbox"/> American Board of Genetic Counseling (ABGC) <input type="checkbox"/> American College of Medical Genetics (ACMG)	Date of issuance (month, year)	Date of expiration (month, year)
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STATE LICENSES

Please list any license, permit, certificate, or registration that you hold to practice genetic counseling or any regulated health occupation in any state, regardless of status.

TYPE OF LICENSE	STATE	LICENSE NUMBER	YEAR OF ISSUE	CURRENT STATUS

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s), case information, detailed description of case / events and settlement amount, including court documents, if applicable. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration or permit to practice genetic counseling or any regulated health occupation in any state (<i>including Indiana</i>) or country, or surrendered your license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you now being, or have you ever been treated for drug or alcohol abuse or addiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been the subject of an investigation by a regulatory agency concerning any licenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been convicted of, plead guilty or <i>nolo contendere</i> to, or are charges pending:	<input type="checkbox"/> Yes <input type="checkbox"/> No
A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Any offense, misdemeanor or felony in any state? (<i>Except for minor violations of traffic laws resulting in fines.</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (<i>month, day, year</i>)
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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for medical licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Agency and the Medical Licensing Board of Indiana from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	Date signed (<i>month, day, year</i>)
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COMPLETE THIS PAGE ONLY IF APPLYING FOR A TEMPORARY PERMIT.

An applicant who is applying for a temporary permit must take and pass the next available examination for certification and may only practice under the temporary license if directly supervised by a licensed genetic counselor or licensed physician.

SUPERVISOR'S STATEMENT		
Name of supervisor (<i>last, first, middle</i>)		
Profession	License number	Date license expires (<i>month, day, year</i>)
Residence address (<i>number and street or rural route, city, state, and ZIP code</i>)		
Office address (<i>number and street or rural route, city, state, and ZIP code</i>)		
Residence telephone number ()	Office telephone number ()	E-mail address

CERTIFICATION OF SUPERVISION	
Please indicate by signing your name below that the genetic counselor on this application (supervisee) will be under your continuous supervision and that you have a supervision contract on file with both parties that sets forth the manner in which you will: <ul style="list-style-type: none">• Assess and document the professional competence, skill and experience of the supervisee;• Determine the nature and level of the supervision required by the supervisee;• Convene monthly to review clinical services and administrative practices;• Conduct monthly chart or case reviews; and• Provide coverage during absence, incapacity, infirmity or emergency	
Signature of supervisor	Date (month, day, year)