TO: Applicants for Genetic Counselor Licensure

FROM: Dawn Beahl, Genetic Counselor Coordinator

RE: Licensure as a Genetic Counselor

You are required to complete and submit the following addendum documents. Your application for genetic counselor licensure will not be considered complete until this information has been submitted to the Board at the address noted above.

- FORM 1: ABGC/ABMG Verification — send this form along with corresponding payment to the ABGC or ABMG

- FORM 2: Verification of Certification — complete the top portion only of this form and send it to each state board in which you are now or have ever been certified or licensed. The verification must come directly from the state.

- FORM 3: Recent original photograph of yourself (passport size) signed and dated.

- FORM 4: Request for Temporary License — Please note that if you are granted a temporary license, you shall apply for and take the examination for certification within twelve (12) months of the issuance of the temporary license; and, you may only practice if you have entered into a genetic supervision contract and are directly supervised by a licensed genetic counselor or a licensed physician. A temporary license will expire thirty (30) days after failing to pass the complete certification examination.

- FORM 4(a): Supervisor’s Statement and Certification of Supervision — to be completed by a supervisor only if applying for a temporary license.

- APPLICATION FEE: $150.00 Check or Money Order made payable to KBML.

Faxes Will Not Be Accepted
APPLICATION FOR GENETIC COUNSELOR LICENSURE IN KENTUCKY

5150.00 Application Fee
(Please Type or Print)

Note: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer 'yes' to any question if the event(s) described in that question has actually occurred. You must answer 'yes' in such circumstances even if you have been advised by an attorney or other person that you may answer 'no'. You must also answer 'yes' in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated 'confidential' by the body involved. After answering 'yes' to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated 'confidential,' attorney has advised that you properly answer 'no'). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer 'yes' to a question, you should err in favor of answering 'yes' and provide an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your certification.

Please circle one: Mr./Mrs./Ms./Miss

1. Name: ___________________________ (first) ___________________________ (middle) ___________________________ (last)

2. Mailing Address: ___________________________ (street) ___________________________ (city) ___________________________ (state) ___________________________ (zip)

3. Practice Address: ___________________________ (street) ___________________________ (city) ___________________________ (state) ___________________________ (zip)

4. Social Security Number: _____ - _____ - ____ Email Address ___________________________

5. Phone: (work) ___________________________ (cell) ___________________________ (home) ___________________________

6. Place of Birth: ___________________________ Date of Birth: ___________________________

7. Have you been known by any other name ☐ YES ☐ NO

If yes, please list names: ___________________________

8. Are you a current Kentucky resident? ☐ YES ☐ NO

9. Are you a U.S. Citizen? ☐ YES ☐ NO


_________________________ (street) ___________________________

_________________________ (city) ___________________________ (state) ___________________________ (zip)
11. Are you currently certified and active by the following:

- American Board of Genetic Counseling  □ YES □ NO
- American Board of Medical Genetics  □ YES □ NO

If YES, Cert # _________ Issue Date ____________ Expiration Date ____________

Date passed examination (month, year) ______________________________________

New graduates, please specify the date you are scheduled to take the exam: _________

12. List all states in which you have applied for or been granted certification/license as a genetic counselor.

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<tr>
<th>State</th>
<th>Cert/Lic#</th>
<th>Issue Date</th>
<th>Exp Date</th>
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13. Have you had any certificate, license, registration or other privilege to practice as a health care professional, denied, revoked, suspended, probated, or restricted by a State or Federal authority, or have you ever surrendered such credential to avoid or in connection with disciplinary investigation/ action by such jurisdiction?

□ YES □ NO

14. Are any legal proceedings regarding certification/license presently pending against you by any State or Federal licensure authority or any drug licensure/enforcement authority?

□ YES □ NO

15. Have you been convicted of a felony or misdemeanor by any State or Federal court? Are any criminal charges presently pending against you in any of these courts?

□ YES □ NO

16. To your knowledge, are you the subject of an investigation for a criminal act?

□ YES □ NO

17. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Authority?

□ YES □ NO

18. Have you ever been denied a license/certificate or denied the privilege of taking a licensure/certification examination by any State, Federal or International licensure jurisdiction?

□ YES □ NO

19. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?

□ YES □ NO
Name: ___________________________ Social Security Number: ___________________________

20. Have you been or are you currently under investigation by any State or Federal licensure authority or any drug licensure/enforcement authority?
□ YES □ NO

21. Have you ever voluntarily or involuntarily surrendered a certificate or license issued to you?
□ YES □ NO

22. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
□ YES □ NO

23. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
□ YES □ NO

If you answered "YES" to any of the above questions (213-23), you must attach a written explanation.

AFFIDAVIT OF APPLICANT: I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

_________________________________________  ___________________________
Signature of Applicant  Date

Subscribed and sworn before me by the above named applicant this

_________ day of ________________  __________

This application consists of 4 pages.

_________________________________________
Signature of Notary

My Commission expires: ___________________________

Seal of Notary
Name: ____________________________________________ Social Security Number: _____________________________

Category II Questions:

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (i) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them. 'Illegal drug use' means the use of an illegally obtained controlled substance or dangerous drug; the term 'illegal drug use' also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the instructions of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
   - YES  NO

2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
   - YES  NO

3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
   - YES  NO

4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
   - YES  NO

5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
   - YES  NO

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

__________________________________________
(Signature of Applicant)

__________________________________________
(Print Name)

Subscribed and sworn to before me by the above named applicant this ______ day of ______, ______

__________________________________________
(Signature of Notary)

Seal of Notary

My commission expires: ____________________________
Kentucky Board of Medical Licensure  
310 Whittington Parkway, Suite 1B  
Louisville, KY 40222  
(502) 429-7150

APPLICATION FOR GENETIC COUNSELOR Licensure IN KENTUCKY  
ABGC/ABMG VERIFICATION

Please complete this form as well as one of the following forms and mail it to the corresponding address below, along with the proper payment:

Send to:

(a) American Board of Genetic Counseling  
4400 College Blvd, Ste 220  
Overland Park, KS 66211  
No Fee if Dues Are Current

(b) American Board of Medical Genetics  
9650 Rockville Pike  
Bethesda, MD 20814-3998  
$60.00

To Be Completed By Applicant (Please Print In Ink)

Dear ABGC/ABMG Official:

I am applying for a license to practice as a genetic counselor in the Commonwealth of Kentucky. By signing this document I authorize you to release my exam scores and proof of my certification directly to the Kentucky Board of Medical Licensure.

Applicant’s Name: ___________________________________________  
(First) (Middle) (Last)

Certificate Number: ________________  
Signature for Release of Information

PLEase MAIL scores DIRECTLY TO:

Kentucky Board of Medical Licensure  
310 Whittington Parkway  
Suite 1B  
Louisville, KY 40222

OR

By email to dawn.beahl@ky.gov
Verification of Certification

Genetic Counselor

Please complete this section of the form and mail to each state board in which you are now or have ever been licensed. If needed, you may duplicate this form.

As part of the application for licensure as a genetic counselor, the Kentucky Board of Medical Licensure requires this form to be completed by each state in which I hold or have ever held certification or licensure. I hereby authorize the release of any information in our files, favorable or otherwise to be sent directly to the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, KY 40222.

Signature

Name

Address

Certificate/License Number

State of Certificate/Licensure # Issue Date

Full name of Certificate Holder

By: Endorsement/Reciprocity with

By: Your State Board's Written Examination

Is Certificate Current? If NO, Why?

Has certificate been subject to disciplinary action by your agency? If YES, please attach copies of any formal orders of your agency and minutes of agency decisions.

Comments, if any

Signed:

Board Seal

Title:

Date:
Once the application has been received and is complete, it will be presented to the Kentucky Genetic Counselors Advisory Committee for their consideration. If the Committee determines that you have met the statutory requirements for licensure, your application will then be presented to the Kentucky Board of Medical Licensure for final approval.

Should you have any questions regarding this application, please contact Ms. Dawn Beahl at (502) 429-7938.

Please attach an original passport sized photograph.

Name: ________________________________

Last 4 Digits of Social Security Number: _______________________

Signature: ________________________________

Date: ________________________________
Genetic Counselor

Request For Temporary License

Please complete this request should you require that temporary licensure be issued prior to the next Board meeting. Once your application process is complete, a temporary license will be issued. The review process for temporary approval takes approximately one to two weeks. Important Notice: You are only eligible for a temporary license if you have been granted an active candidate status by the ABGC. If you are granted a temporary license, you shall apply for and take the examination for certification within twelve (12) months of the issuance of the temporary license. In addition, you may only practice if you have entered into a genetic counselor contract and are directly supervised by a licensed genetic counselor or a licensed physician.

If Interested In A Temporary License, Please Complete The Following:

Name: ________________________________________________

Anticipated Starting Date: _______________________________

Do you currently have active status with the following?

American Board of Genetic Counseling    □YES □NO

If yes, Certification # ____________ Issue Date ____________ Expiration Date ____________

Temporary Licenses Are Only Valid For Up To Twelve Months and will expire thirty (30) days after failing to pass the complete certification examination.

And Cannot Be Extended Or Renewed
COMPLETE THIS PAGE ONLY IF APPLYING FOR A TEMPORARY LICENSE. Form 4(a)

An applicant who is applying for a temporary license must take and pass the examination for certification within twelve (12) months of the issuance of the temporary license and may only practice if he or she has entered into a genetic supervision contract and is directly supervised by a licensed genetic counselor or a licensed physician. A temporary license will expire thirty (30) days after failing to pass the complete certification examination.

**SUPERVISOR’S STATEMENT**

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<th>Name of supervisor (last, first middle)</th>
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<tr>
<th>Profession</th>
<th>License number</th>
<th>Date license expires (month, day, year)</th>
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<th>Office address (number and street city, state and ZIP code)</th>
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<th>Office telephone number</th>
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**CERTIFICATION OF SUPERVISION**

Please indicate by signing your name below that the genetic counselor on this application (supervisee) will be under your supervision and that you have a supervision contract on file with both parties that sets forth the manner in which you will:

- Assess the work of the genetic counselor with a temporary license including regular meetings and chart review.
- Attestation that a supervision contract signed by both the supervisor and the temporarily licensed genetic counselor is on file with both parties.

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<th>Signature of supervisor</th>
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SUPERVISING GENETIC COUNSELOR CONTRACT

This section must be completed by the supervising GENETIC COUNSELOR(s) and should be kept on file in the provider's office.
(This page may be duplicated as necessary)

List all practice settings:

1) Setting: Supervising Genetic Counselor

Printed Name

Address

Signature of Supervising Counselor

2) Setting: Supervising Genetic Counselor

Printed Name

Address

Signature of Supervising Counselor

3) Setting: Supervising Genetic Counselor

Printed Name

Address

Signature of Supervising Counselor

4) Setting: Supervising Genetic Counselor

Printed Name

Address

Signature of Supervising Counselor