Reset Form

APPLICATION FOR A LICENSE TO PRACTICE AS A GENETIC COUNSELOR

State Form 54121 (R7 / 1-21)

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

INSTRUCTIONS:
1. *The fee for this application is $40.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 14-3-1.*
2. *If applying for a temporary permit, please include a fee of $10.00 in accordance with 844 IAC 14-3-1.*
3. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; 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 *

Date of birth (*month, day, year*)

Gender ** ☐ Male ☐ Female

Address of applicant (*number and street or rural route*)

City, state, and ZIP code

Telephone number (*daytime*) ( )

E-mail address *(Required to receive status updates on your application.)*

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select ONLY ONE of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ I am authorized by the Federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No

Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

Do you desire a temporary permit? ☐ Yes ☐ No

If yes, date of scheduled examination *(month, day, year)*

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)*	☐ American Board of Genetic Counseling (ABGC) ☐ American College of Medical Genetics (ACMG)	Date passed examination *(month, year)*

BOARD CERTIFICATION

Type of certification *(check one)*	☐ American Board of Genetic Counseling (ABGC) ☐ American College of Medical Genetics (ACMG)	Date of issuance *(month, year)*	Date of expiration *(month, year)*

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

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the 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?	☐ Yes	☐ 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 (*including Indiana*) or country, or surrendered your license?	☐ Yes	☐ No
3. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice genetic counseling in a competent and professional manner?	☐ Yes	☐ No
4. Have you ever been the subject of an investigation by a regulatory agency concerning any licenses?	☐ Yes	☐ No
5. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*		
(1) have you ever been arrested;	☐ Yes	☐ No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	☐ Yes	☐ No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	☐ Yes	☐ No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	☐ Yes	☐ No
(5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	☐ Yes	☐ 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?	☐ Yes	☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes	☐ No

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 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 information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

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

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (*month, day, year*)

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 (*last, first, middle*)			
Profession		License number	Date license expires *(month, day, year)*
Residence address (*number and street or rural route, city, state, and ZIP code*)			
Office address (*number and street or rural route, city, state, and ZIP code*)			
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: ● 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)*