

GENETIC COUNSELOR REFERENCE FORM

In order for the Georgia Composite Medical Board to adequately evaluate the applicant named below for certification to practice as a Genetic Counselor in the State of Georgia, please complete all pertinent sections in detail. This reference form must be **completed and signed by a supervisor** with whom the applicant practices with at the time of application.

This form can be scanned and emailed **directly from the supervisor** with whom the applicant practices with at the time of application to the Georgia Composite Medical Board at the email address below. Emails must come from a practice or hospital email address of the person completing the reference form. NO personal email accounts (Gmail, Yahoo!, etc.).

Send completed forms to: medbd@dch.ga.gov

Section 1: - To Be Completed by Applicant:

Name: Last: _____ First: _____ M.I.: _____ Maiden: _____

Mailing Address: _____

Telephone Number: _____

Place of Employment or College Clinical if you are a student: _____

City & State of location indicated above: _____

Please evaluate the applicant in the following areas:

	Excellent	Good	Average	Poor	Not able to make judgment
Dependability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reference Form Continued On Next Page

**GENETIC COUNSELOR REFERENCE FORM
(continued)**

Name: Last: _____ First: _____ M.I.: _____ Maiden: _____

(If the applicant is a student, you can omit this section)

Date Employment Started: month/ _____ day/ _____ year/ _____

In your professional opinion is the applicant capable of performing competently as a Genetic Counselor?

Yes No

Would you recommend based on applicant's abilities? Yes No

If no, please explain.

(If the applicant is a student, you can omit this section)

I hereby certify that the above applicant is or has been employed under my supervision as a genetics counselor **from (mm/yy)** _____ / _____ **to (mm/yy)** ____ / ____

Applicant worked full time part time, approximately ____ hours per week.

Would you rehire? Yes No If no, please explain.

Additional Comments:

If you are completing this reference form, please list the name of the business, hospital, or school where you are currently practicing.

Name of Business, Hospital or School: _____

City & State of above location: _____

Physician or Certified Genetic Counselor's Name: _____

(type or print)

Physician or Certified Genetic Counselor's Signature: _____

(Signature required)

License Number: _____ **State of Licensure:** _____

Business Telephone Number: _____ **Date:** _____