LICENSE VERIFICATION

To be completed by the applicant. Original verification history of all licenses you have held or currently hold is required – even if you have not worked in that state for 20 years or you got a license and never practiced in that state. List the State/Country, dates of licensure, licensed by examination, reciprocity, state board examination. <u>This form should be sent to each state in which you are now or ever have been licensed to practice</u>. **This form may be photocopied**.

то:	Board			
FULL NAME	STR	EET ADDRESS		APT. NO.
SIGNATURE	CIT	Y	STATE	ZIP

The individual listed above has applied for licensure in Georgia. Before further consideration is given to this application, we need the information requested on this form. By signing this form, I give my consent to the release of any information, favorable or otherwise, for its review in considering me for licensure. Please mail the completed form as soon as possible to the Board at the address listed below.

	Georgia Composite Medical Board <u>medbd@dch.ga.gov</u> Subject: Genetic Counselor Verification for [insert name of applicant]								
Title of License:					mber:				
Ori	ginal issue date:				Expi	ration	date:		
Lic	ense status:	[] Active	[] Inactive	[] Temporary [] Other		
Lic	ensure Method:	[] Grandfathering	[] Endorsement	[] Examination		
	If licensed by ex	ami	nation, complete the f	followi	ng:				
Na	me of Examinatior	ו:			Leve	l of Ex	amination:		
Date of Examination:			Score Achieved:						
1.	<i>·</i> ·		action ever been take Board with any docum	-	-	-	[] NO ry action.		
2.	Do you have der	oga	tory information conc	erning	this applicant? [YES	[] NO		
	Print Name				-		Date		
	Signature				-		Phone Number		
	Title	BOARD SEAL MUST BE IMPRINTED				OARD SEAL MUST BE IMPRINTED HERI			