GEORGIA COMPOSITE MEDICAL BOARD
2 Peachtree Street, N.W., 6th Floor • Atlanta, Georgia 30303 • Telephone: 404.656.3913 • Fax: 404.656.9723
http://www.medicalboard.georgia.gov

APPLICATION INSTRUCTIONS FOR GENETIC COUNSELORS

Please read these instructions and the laws governing the practice of Genetic Counselors before completing your application. The Board strongly encourages the use of our website at www.medicalboard.georgia.gov to download application information.

Genetic Counselor applications are good for **one-year only** from date of receipt. **APPLICATIONS WILL NOT BE REVIEWED WITHOUT APPLICATION FEE.**

NOTE: WE WILL DISCUSS APPLICATION STATUS WITH THE APPLICANT ONLY UNLESS A SPECIFIC POWER OF ATTORNEY FORM IS ON FILE.

APPLICATION PROCESSING

It is important to make sure to include your application fee at the time you submit your application. Staff cannot begin the initial review of your application without the fee. Within **10 business days** after receipt of your application, a status letter will follow identifying outstanding documentation, if any, to make your file complete. Submit all required documentation as soon as possible. It is recommended that applicants wait **15** business days, after mailing their application, or until receipt of a deficiency letter, to contact the staff by phone regarding the status of their application. It is imperative for applicants to understand that the review process is guided by the requirements set forth in State law, which does not provide for any waivers to be granted by staff.

BOARD MEETINGS

In order for an application to go before the Medical Board for approval, it must be received as completed **10 business days** before the next scheduled board meeting. Completion of an application is when all primary source documentation has been received and reviewed, your application has met all administrative screenings, a final quality assurance review has been completed on your application, and you have been **advised in writing** from the Board.

INTERNET DISCLOSURE OF GENETIC COUNSELOR ADDRESS

Georgia law requires the Georgia Composite Medical Board to provide, upon written or verbal request, an address for each licensed Genetic Counselor. Public-record information pertaining to licensed Genetic Counselor is available to the public through the Board's website (www.medicalboard.georgia.gov).

The release of this information has highlighted the need for individuals to carefully consider the address they provide to the Board as their address of record. The address you indicate as your address of record will be the address disclosed to all individuals making inquiries and will be utilized to mail all licenses, renewal notices, and other official correspondence from the Board.

You may choose your home address or your office address to be your address of record. If you list a P.O. Box as your primary address, you must also provide a secondary street address that will remain confidential. Georgia law requires that the Board be kept informed of any changes of address. Changes should be submitted in writing to the above address, and should include the license number, name, old address and new address.

❑ **CONTACT INFORMATION**
Please email pwhite@dch.ga.gov regarding the status of your application.

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CHECKLIST FOR GENETIC COUNSELORS

THIS CHECKLIST is intended to assist you with the filing of a complete application. Read all instructions on each page carefully and utilize the checklist as you are filling out the application. All items listed that apply to your situation must be submitted in order for your qualifications for licensure to be assessed. When submitting copies of documents, please ensure they **are 8-1/2 x11-inch copies** of the original. *Do not submit two-sided copies of the application or documentation.* **For quality and confidential purposes, facsimiles of application materials are not accepted. All application material must be original, unaltered, and official where required.**

LICENSURE FEES:

MAKE YOUR CHECK OR MONEY ORDER PAYABLE TO GCMB. The FEE MUST ACCOMPANY THE APPLICATION OR THE APPLICATION WILL NOT BE PROCESSED. IF YOUR CHECK IS RETURNED FOR INSUFFICIENT FUNDS, APPLICATION PROCESSING WILL STOP. PROCESSING WILL RESUME ONCE THE OUTSTANDING FEES ARE RECEIVED.

APPLICATION FEE: ***Please make your check/money order payable to: Georgia Co*****mposite Medical Board**

- ☐ **$300.00 (NON-REFUNDABLE FEE) INITIAL LICENSURE FEE**
- ☐ **$100.00 (NON-REFUNDABLE FEE) TEMPORARY LICENSE FEE**

LICENSURE REQUIREMENTS:

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.

- ☐ **INITIAL APPLICATION PAGES 1 – 7.** These pages must be completed in all areas.

- ☐ **PAGE 7 - AFFIDAVIT OF APPLICANT**
  Read this form in its entirety and complete all areas. **A current passport photo is required to complete this form.** Do not submit photos from digital reproductions, magazine, yearbook, wedding, birthday, family outing, etc. Take this form to a notary public for witness of your signature. **The applicant's signature date and the notary signature date must match. No whiteouts or strikeouts are accepted.**

FORMS

- ☐ **FORM 1 - American Board of Genetic Counseling (ABGC) or the American Board of Medical Genetics (ABMG) Verification. Please visit the website to submit a request that your verification be sent to the GCMB.**

- ☐ **FORM 2 - STATE BOARD LICENSE VERIFICATION**
  Complete the top portion 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.
  Original official, certified verifications of license history of all medical licenses you have held or currently hold is required for each permanent, temporary, training, provisional or limited license held, even if you have not worked in that state or in any state in the US or Canadian territory or province, and US federal jurisdiction 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.

- ☐ **FORM 3 - SPECIFIC POWER OF ATTORNEY FORM**
  NOTE: WE WILL DISCUSS APPLICATION STATUS WITH THE APPLICANT ONLY, UNLESS A SPECIFIC POWER OF ATTORNEY AFFIDAVIT IS ON FILE WITH THE BOARD. Applications are confidential pursuant to

State law. Therefore, application status updates must be obtained from the applicant. Please inform all hospitals, employers, recruiters, referral companies, family members, or insurance companies that application status updates must be obtained from you. A Specific Power of Attorney Form is included with the application packet for your use, if you want an agency or other individuals who you designate to handle the application process. The Specific Power of Attorney form must be **signed and notarized** in order to be accepted by the Medical Board.

❑ **FORM 4**

If you are a U.S. Citizen, you may submit a copy of your U.S. passport, driver's license, or birth certificate.

If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. **Only those applicants who can provide proof will be granted a license.** The Board participates in the **DHS-USCIS SAVE** (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens.

In order to confirm your status with the SAVE program, you need to provide the board with **legible** copies of **one** of the following document(s):

1. Valid (not expired) foreign passport with I-94 or I-551
2. Temporary resident alien card (I-688)
3. Permanent resident alien card (I-551)
4. Employment Authorization Card (I-766) or (I-688A)
5. Employment Authorization Document (I-688B)
6. Refugee Travel Document (I-571)
7. Reentry Permit (I-327)
8. Certificate of Citizenship
9. Naturalization Certificate
10. Machine Readable Immigrant Visa (with Temporary I-551 Language)
11. Temporary I-551 Stamp (on passport of I-94)
12. I-94 (Arrival/Departure Record)
13. I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status)
14. DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

Please be sure that copies of any submitted documents are legible. Use a good quality copier and increase the size of the copy if need be. If the following information is needed, it must be legible: Alien Number; Card Number; Document Expiration Date; SEVIS ID Number. One or all of these numbers or dates may be required when we submit your information to SAVE. If we cannot read what you have submitted, we will be unable to submit your information to the SAVE program, which will delay the consideration of your application.

❑ **FORM 5 - REFERENCE FORM**

In order for the **Georgia Composite Medical Board** to adequately evaluate the applicant to practice as a Genetic Counselor in the State of Georgia, a reference form is required. This reference form must be completed and signed by a supervisor with whom the applicant practices with at the time of application. An original signature is required.

This form must be mailed **directly from the supervisor** with whom the applicant practices with at the time of application to the Georgia Composite Medical Board.

REPORT REQUEST

❑ **HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB)**

This data bank is mandated by Congress to track regulatory Board disciplinary actions and certain actions resulting from peer review and malpractice payments. This is to advise that **you must self-query** the HIPDB on your own as part of the application process for a Georgia license. Simply query the data bank using the Internet address at www.npdb-hipdb.com, then click on Perform a Self-Query from the Quick List on the home page, or call 1-800-767-6732 from 8:30 am to 6:00 pm EST (8:30 to 5:30 on Fridays). When you receive the response, **do not open the envelope – send the envelope, unopened, directly to the Board along with your application packet. Altered envelopes which contain official, original, certified official documents will not be accepted**.

Genetic Counselor
Request for Temporary License

☐ **REQUEST FOR TEMPORARY LICENSE APPLICATION – 3 PAGES.**

Temporary licenses are only valid for up to eighteen (18) months and cannot be extended or renewed.

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 license genetic counselor or a licensed physician.

You are required to complete and submit the following addendum documents with your application. Your application for a temporary license for genetic counselor will not be considered complete until this information has been submitted to the Board.

☐ **Supervisory Statement Form**
☐ **Active candidate status by the ABGC**
☐ **<u>FORM 6 – PRIMARY SUPERVISOR SEPARATION NOTIFICATION FORM (TEMPORARY APPLICATIONS)</u>**
If you have a temporary license and no longer work with the supervisor, you must complete this form.

ATTACH CHECK HERE

GEORGIA COMPOSITE MEDICAL BOARD
EFFECTIVE
JULY 1, 2001
ALL FEES ARE NONREFUNDABLE

APPLICATION FOR LICENSURE
GENETIC COUNSELORS

Please be aware that falsification or misrepresentation of any item or response on this application or any attachment hereto is sufficient basis for denying or revoking a license.

BASIC INFORMATION

PLEASE PRINT CLEARLY OR TYPE IN BLACK INK.

1. US Social Security Number: _____-_____-_____ _____ _____ _____

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information also may be disclosed to the Healthcare Integrity and Protection Data Bank (HIPDB) or other state medical boards or regulatory agencies for license tracking purposes.

2. LAST NAME	FIRST NAME	MIDDLE NAME	DEGREE

MAIDEN NAME	SEX M F	DATE OF BIRTH (MM/DD/YY)	

3. Mailing address – This address will be used to mail application status information.			
STREET NUMBER	STREET NAME		APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
( )	( )		@
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		E-MAIL ADDRESS

4. Practice street address – This address will appear on the internet.			
STREET NUMBER	STREET NAME		SUITE #
CITY	STATE	ZIP CODE	COUNTY
( )	( )		
(AREA CODE) PHONE NUMBER	(AREA CODE)		FAX NUMB

Name:_____

CERTIFICATION INFORMATION

I am currently certified and active by the following:

American Board of Genetic Counseling (ABGC) ____**YES** ____**NO**

If Yes, Certification#_____**Issue Date**_____**Expiration Date**_____

American Board of Medical Genetics (ABMG) ____**YES** ____**NO**

If Yes, Certification#_____**Issue Date**_____**Expiration Date**_____

New graduate, indicate the date you are scheduled to sit for the examination and the name of examination:

DATE SCHEDULED TO SIT FOR EXAMINATION: _____

NAME OF EXAMINATION: _____

APPLICANT QUESTIONNAIRE –

INSTRUCTIONS: If you answer, "YES" to questions 3-15, you are required to furnish complete details, including date, place, reason and disposition of the matter. Failure to furnish complete documentation may result in a delay in the processing of your application. I understand that my questionnaire may be selected for verification of the information provided. I recognize that providing false information or incomplete information may result in disciplinary actions against my license pursuant to O.C.G.A. §§ 43-1-19 and may result in criminal penalties, up to and including reporting to the Health Integrity and Protection Databank (HIPDB).	**YES**	**NO**
1. Are you a U.S.Citizen? If no, please refer to the applicant checklist listed on our website for acceptable documentation. If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. Only those applicants who can provide proof will be granted a license. The Board participates in the DHS-USCIS SAVE (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens. In order to confirm your status with the SAVE program, you need to provide the board with legible copies of one of the documents listed on our website.		
2. Are you a current Georgia resident?		
3. Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? NOTE: If you are currently enrolled in GAPHP, you may answer NO.		
4. Have you entered a plea bargain, been arrested, indicted or convicted for violating any state or federal law including DUI (excluding minor traffic violations)? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding, or the affording of First Offender Treatment, regardless of whether the adjudication of guilt or sentence is withheld or not entered. If yes, provide a personal narrative of the circumstances surrounding the incident and include a copy of the charges, plea or jury verdict, and final disposition, sentence, probation, and payment of fines.		
5. Have you ever been denied the privilege of taking a licensing or certification examination given by any licensing Board or Agency?		
6. Has any licensing Board or agency ever denied you a certificate or a license?		
7. Has any licensing Board or agency ever taken a public or private disciplinary action against you?		
8. Has any licensing Board or agency ever denied you a certificate, permit or license?		

Name:_____

	YES	NO
9. Have you ever been denied membership in or in any way sanctioned by any Genetic Counselor association, society, or specialty society?		
10. Have you ever been denied membership in, or in any way sanctioned by, any professional association, or society?		
11. Have you ever voluntarily surrendered a license?		
12. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?		
13. Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?		
14. Do you have any applications for licensure pending before any other licensing Board or agency? If yes, please attach a list.		
15. Have you ever had any restrictions as a Medicaid or Medicare provider?		
16. Have you ever served/serving in U.S. armed forces?		
17. Have you been discharged from U.S. armed forces? If yes, provide copy of DD-214.		
18. Have you ever defaulted on child support payments?		

Name:____

LICENSE HISTORY

INSTRUCTIONS: If you are now or have ever been licensed to practice as a Genetic Counselor in another state, original verifications of license history certification is required for each permanent, temporary, training, provisional, or limited license obtained in any state in the US or Canadian territory, Canadian province, or US Federal jurisdiction. The issuing authority should mail the verification to the Medical Board. If licensed by examination, give the state. If licensed by reciprocity, provide the state. Provide the current status of the license: active, inactive, revoked, suspended, probation, limited, etc. You may make copies of this page if more space is needed. Please complete FORM 2 and forward to the issuing State to request verification be sent "directly" to the Medical Board.

STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	

VERSION: 8/6/2021

APPLICANT WORK HISTORY

Name:_____

APPLICANT: Please document your work history.

A. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:____/____/____ MM DAY YEAR TO:____/____/____MM DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME_____PART-TIME	
B. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:____/____/____ MM DAY YEAR TO:____/____/____MM DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME_____PART-TIME	
C. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:____/____/____ MM DAY YEAR TO:____/____/____MM DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME_____PART-TIME	

EDUCATION INFORMATION

Name:_____

If you obtained a baccalaureate degree from a college or university, provide the name of your training program or college. Indicate all beginning and ending months and years. All gaps in the chronological progression of your training must be explained in the **COMMENTS section below** (i.e., leave of absences, sabbaticals, taking a year off to work in order to pay for the next year of training, etc. If you did not obtain a baccalaureate, enter N/A in the college name field.

	Name, Address, City, State of College or University attended: Degree obtained and name of major or program attended Dates of Attendance – Month and Year
Undergraduate	
Graduate	

AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

PHOTO AREA
PASTE A 2 ¼" X 3"
PHOTO HERE.

PHOTO MUST BE OF
YOUR HEAD
AND SHOULDER AREAS ONLY

BOTTOM OF PHOTO (SHOLDERS)

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application for Genetic Counselor Licensure Information and Applicant instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Genetic Counselor rules, and the Board Rules.

I further state that by filing this application for license to practice Genetic Counselor in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I request and authorize any treatment program to release alcohol and drug abuse patient records to the Georgia Composite Medical Board for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of licensure in Georgia.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or International), court, association, institution, or other organization having control of my documents, records and other information pertaining to me, to furnish to the Georgia Composite Medical Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Composite Medical Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

I authorize and request the Georgia Composite Medical Board to obtain any criminal history information concerning me from any authorized law enforcement agency, including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release, discharge, and exonerate the Georgia Composite Medical Board, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite Medical Board.

This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that false swearing may constitute a felony offense under O.C.G.A. 16-10-71. I understand that working and falsely presenting myself to the public as licensed to practice as a genetic counselor is a violation of the Genetic Counselors Act and is a misdemeanor.

SIGNATURE OF APPLICANT	DATE	CITY	COUNTY	STATE

PRINTED NAME OF APPLICANT	Being duly sworn, says that he/she is the person who executed the above application for a license to practice genetic counseling in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.	NOTARY SEAL MUST BE IMPRINTED HERE

Sworn and subscribed to me this_____day of_____, _
_____

_____(Notary Public)

My Commission Expires

_____

FORM 1
ABGC/ABMG VERIFICATION

Please visit the ACMG website at www.acmg.net to submit a request that your verification be sent to the Georgia Composite Medical Board at the email address identified below.

Email: pwhite@dch.ga.gov

FORM 2
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. This form should be sent to each state in which you are now or ever have been licensed to practice. **This form may be photocopied.**

TO: _____ Board

FULL NAME _____ STREET ADDRESS _____ APT. NO.

SIGNATURE _____ CITY _____ 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.

Section II: This Section to be completed by an official of the above referenced Licensing Board.
Do not return this form to the applicant, but mail it directly to:

Georgia Composite Medical Board
ATTN: GENETIC COUNSELOR LICENSURE UNIT
2 Peachtree Street, NW - 6th Floor
Atlanta, Georgia 30303

Title of License: _____ License number: _____

Original issue date: _____ Expiration date: _____

License status: [ ] Active [ ] Inactive [ ] Temporary [ ] Other

Licensure Method: [ ] Grandfathering [ ] Endorsement [ ] Examination

If licensed by examination, complete the following:

Name of Examination: _____ Level of Examination: _____

Date of Examination: _____ Score Achieved: _____

1. Has any disciplinary action ever been taken again this license? [ ] YES [ ] NO
   If YES, provide the Board with any documentation regarding the disciplinary action.
2. Do you have derogatory information concerning this applicant? [ ] YES [ ] NO

Print Name _____ Date _____

Signature _____ Office Number _____

Title _____ Fax Number _____

State Board _____

BOARD SEAL MUST BE IMPRINTED HERE

FORM 3
SPECIFIC POWER OF ATTORNEY

I, _____, do hereby authorize and direct _____and its agents and employees, by this Specific Power of Attorney to carry out and execute certain duties pursuant to my request and necessary in _____'s reasonable judgment in connection with my pursuit of a license to practice as a Genetic Counselor in the State of Georgia ("Licensed State").

It is expressly understood and agreed that this Specific Power of Attorney authorizes _____to make inquiries as to the status of my application for a Genetic Counselor license in the Licensed State. This Specific Power of Attorney does not authorize _____to act on my behalf for any other purpose and shall expire on the date I am granted a license in the Licensed State, the date my application for a Genetic Counselor license is denied, or upon _____'s receipt of written notice from me of revocation of this Specific Power of Attorney.

I hereby release _____and the Licensed State from any and all liability, damages, claims for damages, suits, actions and causes of action which may accrue as a result of _____acting on my behalf in connection with my pursuit of a Genetic Counselor license in the Licensed State.

PRINTED NAME OF APPLICANT _____ SIGNATURE OF APPLICANT _____	Being duly sworn, says that he/she is the person who executed the above application for a license to practice genetic counselor in the State of Georgia; and that all the statements herein contained are true in every respect.	NOTARY SEAL MUST BE IMPRINTED HERE
Sworn and subscribed to me this _____day of _____, _____ _____ ____(Notary Public)	My Commission Expires _____	

FORM 4

O.C.G.A. § 50-36-1(e)(2) Affidavit for Medical Board License

GENETIC COUNSELOR - INITIAL APPLICATION ONLY

INSTRUCTIONS TO APPLICANT:

1. **Be sure to submit the correct type of document with this affidavit.** If you **are not** a citizen of the United States, you must submit a copy of a document we can use to verify your lawful presence, such as your **U.S. Permanent Resident Card, foreign passport with I-94 attached, etc.** If you are a U.S. citizen, you may submit a copy of your U.S. passport, driver's license, birth certificate, etc.

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, from the Georgia Composite Medical Board, the undersigned applicant verifies **one** of the following with respect to my application for a public benefit:

___ 1. I am a United States citizen.

___ 2. I am a legal permanent resident of the United States.

___ 3. I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security. My alien number issued by the Department of Homeland Security is: _____.

___ 4. I am NOT a citizen of the United States, and am NOT physically present in the United States.
Note: If you checked #4 to indicate that you are not a US citizen and are not physically present in the US, submit the affidavit (without any other document) only.

I am 18 years of age or older and have provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit. In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____(state).

_____
SIGNATURE OF APPLICANT NAME OF APPLICANT (PRINT)

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE _____ DAY OF _____, 20_____

_____
NOTARY PUBLIC

My Commission Expires:

Mail this original affidavit and a copy of at least one acceptable verifiable document to:
GEORGIA COMPOSITE MEDICAL BOARD
2 PEACHTREE ST NW, 6TH FLOOR
ATLANTA GA 30303

GENETIC COUNSELOR

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2012 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

☐ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

☐ A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

☐ A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

☐ A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

☐ A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

☐ Certification of Report of Birth issued by the United States Department of State (Form DS-1350) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

☐ Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

☐ Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

☐ An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

☐ In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

FORM 5
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. An original signature is required.

This form must be mailed **directly from the supervisor** with whom the applicant practices with at the time of application to the Georgia Composite Medical Board at the following address:

Georgia Composite Medical Board
Genetic Counselor Unit
2 Peachtree Street, N.W. – 6th Floor
Atlanta, GA 30303

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	☐	☐	☐	☐	☐
Quality of Work	☐	☐	☐	☐	☐
Professional Responsibility	☐	☐	☐	☐	☐

Reference Form Continued On Next Page

FORM 5
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: _____
(Original signature required)

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

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

FORM 6
GENETIC COUNSELORS
PRIMARY SUPERVISOR SEPARATION NOTIFICATION FORM

Please complete this form if you are resigning from your current primary supervisor.

I hereby serve notice to the *Georgia Composite Medical Board* that

_____ is no longer a primary supervisor
Primary Supervisor/GC Full Name – please print legibly

_____effective:_____/_____/_____.
(license number) (Month) (Day) (Year)

For:

_____ _____
Temporary Genetic Counselor Name – please print legibly License Number

_____ _____
Signature Date Signed

Primary Supervisor/GC Statement:

I hereby serve notice to the *Georgia Composite Medical Board, that* I am no longer serving as a primary supervisor for:

_____
Temporary Genetic Counselor Full Name– please print legibly

effective:_____/_____/_____
(Month) (Day) (Year)

_____ _____
Primary Supervisor /GC Full Name Date Signed