ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201-2936
Phone (501) 296-1802 Fax (501) 296-1972
www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

LICENSED GENETIC COUNSELOR INFORMATION PACKET

This packet contains all of the documents you will need to apply for a license in Arkansas. This packet and each of its components are available on our web site, www.armedicalboard.org. If you received this packet from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application will not be accepted.

*** IMPORTANT INFORMATION - PLEASE READ CAREFULLY ***

ABANDONED APPLICATIONS. Applications which are not complete after twelve (12) months will be classified as Abandoned and will be removed from our system. Further, pending applications will be listed as abandoned if the applicant does not communicate with the Board office for six (6) months. Abandoned files will be maintained for 30 days and then destroyed. No refunds will be given on abandoned/inactive applications.

APPLICATION FEES. The fee for full licensure is $5 (five). If you are requesting a temporary license the fee is an additional $3 (three) and must be included with your application at the time of submission. Payment may be made by check or money order payable to ASMB - Arkansas State Medical Board. **Do not send cash.**

APPLICATION REVIEW. The application review process is defined by the requirements set forth in state law. The Board and its staff must comply with those laws in processing applications. Applications are processed in the order in which they are received in our office and in the order verifications are obtained. THE BOARD DOES NOT ACCELERATE ONE APPLICANT OVER ANOTHER.

ARKANSAS MEDICAL PRACTICES ACTS AND RULES. The Arkansas Medical Practices Acts and Rules must be read in their entirety prior to submitting an application for a Genetic Counselor license to the Arkansas State Medical Board. You MUST complete the Arkansas Medical Practices Acts and Rules Affidavit located in this packet. Applications received without this form will be returned. The Medical Practices Act can be viewed and downloaded from our web site, www.armedicalboard.org.

CHANGE OF ADDRESS. Rule 33 requires you to notify the Arkansas State Medical Board of any changes to your address within 30 days of such change. This includes your relocation to Arkansas, if applicable. A Change of Address form is available for download at our website, www.armedicalboard.org. THIS ADDRESS CHANGE MUST BE IN WRITING. The form must be fully completed, signed and dated. Once you are licensed you may change your address online.

CHECKING THE STATUS OF YOUR APPLICATION. The Arkansas State Medical Board's required form of communication is an interactive Applicant Portal system which allows communication between the Board and the applicant via the web. We have found that this system is a very effective communication tool and significantly reduces the time to licensure once your access identification has been assigned. Once your access identification has been assigned, you may access the Applicant Portal system from any computer at any time by visiting the Medical Board's web site at: http://www.armedicalboard.org.

When using the system, you will see a status bar which will show the percentage completed of your application process. Additional information regarding items that need your attention will be provided to you via a “Click here to respond” link on the “Applicant Portal Home” page. You will need to access your open items by choosing this link and providing a response to the items for which a response is requested.

This interactive system allows the Licensing Coordinator the time necessary to work your file as opposed to responding to numerous phone calls or e-mails from various interested parties checking on the status of your application. It also allows you to review the progress of your application at any time. You may choose to provide access to your Applicant Portal to

others; however, once you allow this access, all communication in the system will be viewable. This means that all questions including health or disciplinary issues occurring in other states or institutions will also be viewable.

After all verifications have arrived, your file will be checked to ensure all time gaps have been accounted for in your time line. If they are not, you will be asked to document your activity during those specific times. Although this seems insignificant, it is very important to the Board. This step cannot be skipped. Once all verifications have arrived and all time gaps filled, your application file will be presented for licensure consideration.

APPEARING BEFORE THE BOARD. Prior to your application being placed on the Board Meeting agenda, it must be complete and all required documentation, including staff investigations, must be in this office. THERE ARE NO EXCEPTIONS TO THIS POLICY. Before being granted a license, the following applicants may be required to make a personal appearance before the Board:

- Applicants who have disciplinary actions and/or impairment history
- Applicants with malpractice history (pending or settled)

If you are required to make a Board Appearance, you will be notified of the time and date of your appearance prior to the next scheduled Board Meeting. If your file contains no derogatory information, you may not be required to make a Board appearance. The Board reviews such files weekly. If the Board Members do not have any questions or concerns about your application or documentation, they will approve your application and your license will be issued on the following Friday.

COMPLETING THE APPLICATION. READ THE INSTRUCTIONS FOR EACH QUESTION BEFORE ANSWERING. The application may NOT be submitted electronically or by fax, as we do require your original signature on the hard copy. Please type or print legibly in dark blue or black ink. Provide exact dates (mm/dd/yyyy) whenever possible. ANSWER ALL QUESTIONS/SECTIONS, even if your answer is "n/a," "Not Applicable," "None" or "Pending". All signatures must be the applicant's; stamped signatures, signatures by proxy, and signatures by power of attorney are NOT accepted for documentation or verification purposes. Make sure all required seals are affixed on the application, and all questions have a response. Your application and verifications will be returned to you if they are incomplete or if photos are not attached where required. Pages must be printed on one side only. Two sided (front and back) applications will cause delays due to pages needing to be resubmitted.

CRIMINAL BACKGROUND CHECK. Act 1249 of 2005 authorizes the Arkansas State Medical Board to conduct criminal background checks (both state and federal) on ALL applicants for licensure.
Arkansas Code 17-95-306 states:

(a) (1) Beginning July 1, 2005, every person applying for a license or renewal of a license issued by the Arkansas State Medical Board shall provide written authorization to the board to allow the Arkansas State Police to release the results of a state and federal criminal history background check report to the Board.

(2) The applicant shall be responsible for payment of the fees associated with the background checks.

If you live outside of Arkansas:
Upon receipt in this office of your completed application and fee, a CBC packet, including forms and instructions, will be mailed to your private address for completion. You need to complete and return these forms at your earliest convenience as the Federal portion of this background check can take several weeks or more to process. ASMB will NOT accept a previously obtained criminal background check, regardless of how recently it was performed or what organization provides it. Payment for the CBC must be made by money order. Complete instructions will be provided in the CBC packet. It is vital that the completed CBC packet be returned to the Board in a timely manner as failure to do so will delay licensure.

If you live in Arkansas:
Upon receipt in this office of your completed application and fee, an email will be sent to you from Support@armedicalboard.org regarding the necessary steps to be fingerprinted so your criminal background check can be conducted. It is vital that you follow these instructions as soon as possible to avoid delay in the licensing process.

Act 630 of 2021 was enacted which amended A.C.A. 12-12-1005. Beginning September 1, 2021, paper fingerprint cards (FD-258) are no longer being accepted by the Arkansas State Police for Arkansas residents and requires that background checks must be submitted by electronic means only:

(d)(1)A background check request for a non-criminal justice purpose that must be completed under state or federal law through the Division of Arkansas State Police shall be submitted to the division by electronic means through the Arkansas State Police Criminal Background Check System.

(2) This subsection does not apply to a submission originating outside the State of Arkansas.

Any licensing applicant living within the state of Arkansas will be required to submit their fingerprints electronically via Arkansas LiveScan. Do not do this step until you have received an acknowledgement email from this office. Failure to do so will result in an unsuccessful transmission of your fingerprints.

EXEMPTION FROM LICENSURE. Exemptions from licensure can be found in the Arkansas Medical Practices Act & Rules located at www.armedicalboard.org beginning in A.C.A. 17-95-1103.

LICENSE RENEWAL. Your Genetic Counselor license, if granted, must be renewed bi-annually from the date of issue. There is no grace period. Your first renewal notification will be sent to you via e-mail 60 days prior to the expiration date. A follow-up email will be sent at approximately 45 days and a final email notification will be sent 30 days from the last day of your birth month. Failure to receive notice is NOT considered an excuse for nonrenewal. Failure to renew before midnight on the last day of the expiration month will cause your license to automatically expire. If your license expires, you will be assessed a $50 late fee to reinstate your license.

PROCESSING TIME. Processing delays are almost always attributable to delays in receiving the verification documents you request. If you have a history of disciplinary action, impairment history, etc., additional time will be required for our investigation. Processing a permanent license application will take several weeks to complete. Please plan for this. Do not make commitments, purchase a home, or relocate your family before your Arkansas Licensed Genetic Counselor license has been granted. Applications are processed in the order in which they are received in our office and in the order verifications are obtained. The Board does NOT accelerate one applicant over another.

SUBMITTING THE APPLICATION. The application may NOT be submitted electronically, as we do require your original signature on the hard copy and all fees to be paid at submission.

SUPERVISION. By law, Genetic Counselors who have been granted temporary licensure are allowed to practice only under the supervision of a licensed genetic counselor or a licensed physician with current American Board of Genetic Counseling certification in clinical genetics when the applicant provides genetic counseling services. It is the responsibility of the Licensed Genetic Counselor applicant to keep this office informed of your current Supervisor in Arkansas.

TEMPORARY LICENSES. A temporary license may be granted to an applicant who meets all the qualifications for licensure but is awaiting passage of their certification exam. Consideration of a temporary license can be made only when the application process is completed in its entirety. The temporary license is valid for 1 year from the date of issuance under § 17-95-1106, ninety (90) days after the date that the applicant fails on his or her second attempt to pass the certification examination **or** the date printed on the temporary license. The temporary license can be extended only once. A temporary license shall not be issued if the applicant has failed the American Board of Genetic Counseling certification examination more than two (2) times.

U.S. POSTAL SERVICE. If you choose to utilize the U.S. Postal Service, please be advised that they do NOT guarantee delivery of first class mail, and they do NOT guarantee delivery of Certified mail. Based on the lengthy delays we have experienced in receiving mail which has been sent to us, we strongly recommend you utilize FedEx, UPS, or other *guaranteed* delivery service when sending your application or other documents to us.

VERIFICATIONS. It is the policy of this board that ALL education, training, certification and other licenses be verified by the primary source prior to issuance of a permanent license. It is the applicant's responsibility to request verifications and to follow up with organizations to ensure verifications are returned. Applicants are required to sign verification documents where indicated in Part II prior to sending to verification source. The verifier's signature can be original, stamped or computer-generated. All verifications can be faxed or e-mailed unless specifically requested to be mailed. To fax, send to (501) 296-1972. To e-mail, the document must be sent as an Adobe .pdf attachment to support@armedicalboard.org with "Attn: Licensing" in the Subject line. Note that if the attachments are not sent in this format and to this address, they will be stripped by the firewall and will not be received by the intended recipient. If the verification is sent by fax or email, request that the sender NOT send a hard copy by mail, as duplicate verification will delay the licensure process.

WITHDRAWN APPLICATIONS. Applications which are withdrawn by the applicant will be maintained for 30 days and then destroyed. No refunds are given on applications that are withdrawn.

"YES" RESPONSES. A "Yes" response in the attestation portion of the application does not mean your application will be denied. If you have responded "Yes" to any of these questions, additional time will be required for the gathering and assessment of pertinent information. You will be required to provide a separate, signed and complete explanation for each "Yes" response; you can expedite this process by including these with your original application. Failure to appropriately answer questions may result in an appearance before the Board for full licensure; disciplinary action; and/or denial of a license.

GENETIC COUNSELOR REQUIREMENTS FOR LICENSURE IN ARKANSAS

ARKANSAS MEDICAL PRACTICES ACT, A.C.A.17-95-1106: THE ARKANSAS STATE MEDICAL BOARD SHALL LICENSE AS A LICENSED GENETIC COUNSELOR AN APPLICANT WHO:

- Submits an application on forms approved by the board;
- Pays the appropriate fees as determined by the board;
- Has earned a master's degree from a genetic counseling training program that is accredited by the American Board of Genetic Counseling or an equivalent as determined by the American Board of Genetic Counseling or the American Board of Medical Genetics.
- Meets the examination requirements for certification and has current certification as a genetic counselor by the American Board of Genetic Counseling or the American Board of Medical Genetics.
- Has no licensure, certification, or registration as a Genetic Counselor under current discipline, revocation, suspension, or probation for cause resulting from the applicant's practice as a Genetic Counselor, unless the board considers such condition and agrees to licensure;
- Certifies that he or she is mentally and physically able to engage safely in practice as a Genetic Counselor;
- Submits to the board any other information the board deems necessary to evaluate the applicant's qualifications;

LICENSURE IS BY CREDENTIALS:

- Credentials must be verified from the originating source; verifications received from applicants will be returned.

CERTIFYING EXAMINATIONS MEETING THE BOARD REQUIREMENTS ARE AS FOLLOWS:

- American Board of Genetic Counseling
  or
- American Board of Medical Genetics

LICENSE APPLICATION CHECKLIST

(Use this checklist to be sure your application is complete prior to sending to the Arkansas State Medical Board)

USE THE FOLLOWING ADDRESS FOR ALL DOCUMENT SUBMISSION:

ARKANSAS STATE MEDICAL BOARD
ATTN: LICENSING DEPARTMENT
1401 W CAPITOL AVE, SUITE 340
LITTLE ROCK AR 72201-2936

You are required to provide the following documents to the Arkansas State Medical Board:

- ❑ Check or money order, made payable to *ASMB*, in the amount of $5 (five) for full licensure or $8 (eight) for temporary and full licensure.
- ❑ Application, signed, with current photo attached (no more than 60 days old) and certification by Notary Public. Signature must be original and must be made in black or dark blue ink. Stamped signatures, signatures by proxy and signatures by Power of Attorney are NOT accepted. Do not complete the application on front and back pages. Use one sided pages only.
- ❑ Signed and dated explanations for any "Yes" answers in Part IV of the Application. Attach all pertinent documentation.
- ❑ Completed Genetic Counselor Authorization and Release (form in packet)
- ❑ Completed Arkansas Medical Practices Acts and Rules Affidavit (form in packet)
- ❑ Completed Secondary Contact Designation if desired (form in packet)
- ❑ Current Resume
- ❑ Copy of Driver's License or Passport
- ❑ Copy of name change documents, if applicable
- ❑ Copy of proof of citizenship, naturalization, visa, or work license, if applicable *(if not born in the U.S.)*
- ❑ Copy of DD Form 214 (Certificate of Release or Discharge from Active Duty), if you have been released or discharged from any branch of the U.S. Armed Forces at any time during or since Genetic Counselor School

You are required to request the following documents from their primary sources, and these documents must be sent from the primary source DIRECTLY to the Arkansas State Medical Board:

- ❑ **Verification of Genetic Counselor Education and Official Transcript** (form in packet)
  Complete Parts I and II, sign and then send a copy to the Dean or Registrar of each Genetic Counselor school you attended.

- ❑ **ABCG / ABMG Certification Results/Eligibility**
  Go to www.abgc.net or www.abmgg.org. If you have taken and passed the certification exam, request the verification of certification be sent to this office. If you have not taken the exam, request that proof of eligibility to test be sent to this office.

- ❑ **Verification of Licensure** (form in packet)
  The applicant is not required to request verification of their out-of-state Genetic Counselor licenses, except for those states that do not provide free, online verification through their website. In these states, the applicant will be required to request verification and/or pay any required fees. If any verifying source charges a fee for verification, does not offer online verification, or if their website has not been updated, the applicant is responsible for requesting verification and paying any fees. Complete Parts I and II of the form, sign and then send a copy to the licensing board. Please be mindful of this as failure to do so will cause unnecessary duplication of efforts and **preventable expenses**.

- ❑ **Supervisor Application for a Genetic Counselor Temporary License** (form in packet)
  Send to your Supervisor for completion.

- ❑ **Physicians Health Committee Documents**
  If you are now being or have ever been monitored by a Physician Health Committee in any state or country, ask the director of that program to furnish a copy of your contract and a letter verifying your status. We must also have a PHC-specific Authorization & Release on file. If you are currently under a PHC contract, you must also contact the Arkansas Physicians' Health Committee:

  Arkansas Physicians' Health Committee
  Arkansas Medical Foundation
  10 Corporate Hill, Suite 150
  Little Rock, AR 72205
  (501) 224-9911

INSTRUCTIONS FOR COMPLETING LICENSURE APPLICATION

READ CAREFULLY!

Question 1: Your name

a. Enter your legal name as listed on your driver's license. If your name has changed due to marriage, divorce, adoption or naturalization, submit a notarized copy of pertinent document.
b. Enter any other names used during your education or career, such as maiden name, nicknames, etc.

Question 2: Your identification

a. Enter your social security number.
b. Enter your driver's license number and state of issuance. *Send a copy of your driver's license with your license application.*
c. Check male or female.
d. Enter your date of birth (mm/dd/yyyy).

Question 3: Birthplace/Citizenship

a. Enter the city and state (or city and country) where you were born.
b. Enter the name of the country of which you are a citizen. *If you are a U.S. citizen but you were born in a foreign country, send a copy of your proof of citizenship.*
c. If you are not a U.S. citizen, enter your immigration status. *Send a copy of your current Visa or Work Permit.* If you are a U.S. citizen, enter "n/a".
d. If you are not a U.S. citizen, enter the number of years and/or months that you have lived in the U.S. If you are a U.S. citizen, enter "n/a".
e. Indicate your ethnicity by checking the appropriate box.
f. Indicate your race by checking the appropriate box.

Question 4: Your contact information (Both address sections must be completed, even if they are the same.)

a. Enter your Public mailing address. **This field is required.** This address appears on all printed reports, bulk data listings, the Online Directory and the free, online license verification system. It is also available to the general public under FOI, and all other reports available to the credentialing organizations utilizing the ASMB website for license and/or credentials verification.
b. Enter your Private mailing address. **This field is required**. The Private address is used to send renewal reminders, direct and confidential communication from the Board and the Board's quarterly Newsletter. It is NOT available to the public under FOI ***unless*** you also use this address as your public address.
c-f. Enter your private, work, fax, and mobile phone numbers in the appropriate spaces.
g. Enter your **personal** e-mail address. **Your personal e-mail address is required.** This is the e-mail address through which you will receive automated system messages as to the status of your application. You may also receive private and confidential e-mails for clarification purposes from the licensing staff. This is NOT your primary contact's e-mail address, as this e-mail address will carry over towards the required online renewal setup.

Question 5: Intended Practice Location

a. Enter the name of the hospital, clinic, group or private practice where you will be practicing.
b. Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing.
c. Enter the name of the person that will be your Supervisor (if you are requesting a Temporary License). If you have not found employment at the time of application, enter "pending."

Question 6: Genetic Counselor Program

a. Enter the full name of the Genetic Counselor Program that you attended. The application has space for two different schools in case you transferred. If you attended more than two schools, additional sheets may be attached.
b. Is the Genetic Counselor Program accredited by the ABGC or ABMG? Choose "Yes" if it is accredited by either organization, choose "No" if it is not.
c. Enter the mailing address of the program.
d. Enter the date you started attending the program.
e. Enter the date you left the program (graduated or left before completion).
f. Answer "Yes" if you graduated, "No" if you did not graduate.
g. Enter the degree you were awarded, or list the reason why you did not graduate (transferred schools, extended leave of absence, etc.). *If you did not graduate, you must submit a separate, signed and dated explanation of the circumstances.*

Complete the top portion of the "Verification of Genetic Counselor Education" form contained in the application packet, and send one to each program you attended. Forms must be returned directly to this office from the institution.

Question 7: Examination History

Answer "Yes" if you have passed the ABGC or ABMG Exam.
Answer "No" if you are waiting to take (or have not taken) the ABGC or ABMG Exam.

a. List Exam Series (i.e.; ABCG or ABMG)
b. How many times have you taken the exam?
c. List the number of times you have failed the exam.
d. List the date you passed the exam.

Go to the ABGC website, (www.abgc.net) and go to "ABGC Portal" to request credential verification. If you have taken and passed the exam, request the "Score Report" be sent directly to this office. If you have not taken and passed the exam, request that proof of your eligibility to test be sent directly to this office.

Question 8: Licenses

a. If you have never held a Genetic Counselor license (including temporary licensure) in another state or country, enter "None" in the first space and proceed to Question 8. If you have held a Genetic Counselor license in another state or country, enter the name of that state or country here. The application has space for four licenses; if you have held more than four, additional sheets may be attached.
b. Enter your Genetic Counselor license number.
c. Enter the date the Genetic Counselor license was originally issued.
d. Enter the date the Genetic Counselor license expired or will expire.
e. Enter "Yes" if this license is still active, "No" if it is not.

Question 9: Military Service

a. Check "Yes" if you have ever served in the armed forces of the United States or any other country, "No" if you have not.
b. Enter the country and branch of service in which you served. If you have never served in the military, enter "n/a".
c. Enter the date you entered the military.
d. Enter the date on which you were discharged from the military. If you are still in the military, enter "Current."
e. Enter the type of discharge (Honorable, General, etc.). If you are still in the military, enter "n/a."

If you have been discharged from the U.S. Military, you must provide a copy of your "DD Form 214." If you do not have your DD Form 214, visit the National Personnel Records Center website (http://www.archives.gov/veterans/military-service-records/get-service-records.html) to request Military Service Records be sent directly to this office.

If you are currently in the U.S. Military, you must have your current Commanding Officer submit a verification letter directly to this office OR complete Parts I and II of the "Verification of Current Military Service" form and send it to the appropriate department in the United States military for them to complete and return to this office. Verifications must be returned from the source to this office.

If you served in the military of a foreign country, provide the dates of service. Submit all documentation you have in support of your service to this office.

QUESTIONS 10 - 15 (ATTESTATION QUESTIONS):

For each "YES" response to questions 10 through 15, you must provide a separate, signed and dated statement giving full details, including date, location, type of action, organization or parties involved, and specific circumstances. If you are not sure how to respond to a question, it is best to disclose all information and provide an explanation. Failure to answer these questions completely and accurately may result in disciplinary action or denial of license application.

FOR QUESTION 11, If you answer "yes" to this question, in addition to the written explanation outlined above, you must also attach a copy of the charging document, judgment or conviction, indicate whether paroled or placed on probation, and how probation was completed for any felony conviction received prior to the date of your application.

Affidavit of Applicant (Signature Page):

Read the affidavit completely before signing. Attach a passport-style photo, taken within the past sixty (60) days, in the space shown. You must sign where indicated IN THE PRESENCE OF A NOTARY PUBLIC, swearing you are the person referred to in the application and that all statements contained therein are true and correct. The Notary seal should be affixed below the photograph. The Notary's date must match your signature date. *Applications received without a photo or the required Notary seal will be returned to the applicant for completion, thereby delaying the application process.*

Arkansas State Medical Board
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www.armedicalboard.org

Arkansas State Medical Board – Fee Waiver Form

17-5-104. Fee waiver. [Effective January 1, 2022.]

(a) Notwithstanding any law to the contrary, a licensing entity shall not require an initial fee for individuals who are seeking to receive a license in this state if the applicant:

(1) Is receiving assistance through the Arkansas Medicaid Program, the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, the Temporary Assistance for Needy Families Program, or the Lifeline Assistance Program;

(2) Was approved for unemployment within the last twelve (12) months; or

(3) Has an income that does not exceed two hundred percent (200%) of the federal poverty income guidelines.

(b) The waiver of the initial fee does not include fees for:

(1) A criminal background check;

(2) An examination or a test; or

(3) A medical or drug test.

In accordance with Ark. Code Ann. § 17-5-104, the Arkansas State Medical Board will waive the initial application fee providing the following conditions are met:

Fee Waiver Eligibility
Check all that apply:

- ☐ Arkansas Medicaid Program
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC)
- ☐ Temporary Assistance for Needy Families Program (TANF)
- ☐ Lifeline Assistance Program
- ☐ Have been approved for unemployment within the last twelve (12) months
- ☐ Have an income that does not exceed two hundred percent (200%) of the federal poverty income guidelines

Proof of eligibility* for the fee waiver and this signed form must accompany the application at the time of submission.

_____ _____

Applicant Signature Applicant Printed Name

*Documentation must include:

- Official documentation from the agency providing the benefits that you are receiving that includes your approval for benefit assistance
- Copy of your most recent tax return to show proof of having income that does not exceed 200% of the federal poverty income guidelines

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Are you a current or former member of the U.S. military or a spouse of a current or former member of the U.S. military? ☐ Yes ☐ No

APPLICATION FOR GENETIC COUNSELOR LICENSURE IN ARKANSAS

1. Please read the IMPORTANT INFORMATION and ALL INSTRUCTIONS included in the application packet.
2. Type or print legibly (in dark blue or black ink) all application documents. (One sided documents only.)
3. Provide exact dates whenever possible, in *MM / DD / YYYY* format.
4. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.
5. Give careful thought to each answer because you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Parts IV of the application, you MUST submit a signed and dated explanation.
7. Failure to answer all questions completely and accurately; omitting or falsifying information may be cause for denial of your application or disciplinary action if you are subsequently granted a license. *When in doubt, disclose and explain all information.*

Are you requesting a temporary license? ☐ **Yes** ☐ **No**

PART I - PERSONAL IDENTIFICATION INFORMATION

1a. Full Legal Name (Last, First, Middle, Suffix, Degree)			
1b. Other Names Used (including Maiden Name)			
2a. Social Security Number	2b. Driver's License State & Number	2c. Gender ☐ Male ☐ Female	2d. Date of Birth (mm/dd/yyyy) / /
3a. Place of Birth (City and State/Country)		3b. Country of Citizenship	
3c. Immigration Status (if not U.S. citizen)		3d. How long have you been in the U.S.? (if not U.S. citizen)	
3e. Ethnicity ☐ Non-Hispanic ☐ Hispanic		3f. Race ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Black/African American ☐ White ☐ Hawaiian/Pacific Islander	
4a. Public Address (Street, City, State, Zip Code)			
4b. Private Address (Street, City, State, Zip Code)			
4c. Private Phone #	4d. Work Phone #	4e. Fax #	4f. Mobile Phone #
4g. Personal E-mail Address			
5a. Intended Practice Location in Arkansas: Full Name Hospital, Clinic, Group or Private Practice			
5b. Mailing Address of Intended Practice Location (PO Box or Street, City, State, Zip Code)			
5c. Name of Supervisor (If requesting a temporary license)			

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Application Received: / /	Fee Received: $	PHID No.
Temp License #:	Temp Issued: / /	Temp Expires: / /
LGC License #:	Full License Issued: / /	

PART II – EDUCATION

GENETIC COUNSELOR PROGRAM List in chronological order all Genetic Counselor Programs you attended (attach additional sheets if necessary). Have each school complete and send Verification of Genetic Counselor Education form **and** official transcript directly to this office.

6a. Full Name of Institution and Program			6b. Program Accredited by ABGC or ABMG? ☐ Yes ☐ No
6c. Mailing Address (Street Address, City, State, Zip Code)			
6d. Start Date / /	6e. End Date / /	6f. Graduated? ☐ Yes ☐ No	6g. Degree Awarded, or reason why you did not graduate

6a. Full Name of Institution and Program			6b. Program Accredited by ABGC or ABMG? ☐ Yes ☐ No
6c. Mailing Address (Street Address, City, State, Zip Code)			
6d. Start Date / /	6e. End Date / /	6f. Graduated? ☐ Yes ☐ No	6g. Degree Awarded, or reason why you did not graduate

EXAMINATION HISTORY

Have you passed the ABGC or ABMG Exam? ☐ Yes ☐ No	If Yes, have certification from ABGC or ABMG mailed directly to this office. If No, enter date exam scheduled _____

Please specify exam series (ABGC or ABMG):

7a. Exam Series	7b. Number of Attempts	7c. Number of times failed	7d. Date PASSED / /

PART III - PROFESSIONAL

PROFESSIONAL LICENSURE List all states or territories of the United States, provinces of Canada, or other countries in which you hold or have ever held a Genetic Counselor license. Attach additional sheets if necessary.

8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)
8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)
8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)
8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)

MILITARY SERVICE Submit a copy of your separation papers (DD Form 214) with your application. If Active Duty, have the Verification of Current Military Service sent to this office or have your current Commanding Officer submit a verification letter directly to this office.

9a. Have you ever been in the armed forces? ☐ Yes ☐ No *If yes, complete questions 9b - 9e.*

9b. Country & Branch of Service	9c. Date of Entry / /	9d. Date of Discharge / /	9e. Type of Discharge

PART IV - ATTESTATION QUESTIONS

SPECIAL INSTRUCTIONS FOR QUESTIONS 10-15

- Please mark the appropriate box next to each question. Do not leave any questions blank.
- For each "Yes" response to questions 10-15, you must provide a separate, signed and dated statement giving full details including date, location, type of action, organization or parties involved, and specific circumstances. **If you are not sure about how to respond to a question, it is best to disclose all information and provide an explanation.**
- Failure to answer these questions accurately may result in disciplinary action or denial of license application.
- Confidentiality: The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

10.	Have you ever obtained or attempted to obtain a license by fraud or deception? If yes, explain.	☐ No ☐ Yes
11	Have you ever been convicted of a felony under state or federal law? *If yes, explain*.	☐ No ☐ Yes
12.	Have you ever been adjudicated mentally ill or incompetent by a court? *If yes, explain*.	☐ No ☐ Yes
13.	Have you ever used illicit drugs or intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants to an extent that adversely affects the practice of genetic counseling? *If yes, explain.*	☐ No ☐ Yes
14.	Have you ever engaged in unethical or unprofessional conduct, including without limitation willful acts, negligence, or incompetence in the course of professional practice? *If yes, explain.*	☐ No ☐ Yes
15.	Have you ever been denied licensure or disciplined in another state or territory in connection with a license in another state or territory? *If yes, explain.*	☐ No ☐ Yes

continue to next page

PART V - AFFIDAVIT OF APPLICANT

I, the undersigned applicant, after being duly sworn, hereby certify that I have read the complete application and know the full content thereof. I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true, correct, current, and complete to the best of my knowledge. I certify that the photograph that appears below is a true likeness of me, taken within the past sixty (60) days. I understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, even if submitted separately, is sufficient grounds for denying, revoking, or otherwise disciplining a license to practice as a Licensed Genetic Counselor in the State of Arkansas.

AFFIX
PASSPORT-STYLE
PHOTOGRAPH
HERE

DO NOT STAPLE

_____

Applicant's Signature (in ink)
(must be signed in the presence of a Notary Public)

_____

Date Signed
(must include the month, day and year signed)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the State of _____, this _____ day of _____, 20 _____.
(Notary date must be the same as the applicant's signature date above)

My commission expires: _____

_____

Notary Signature
(Notary seal must be below the photograph at left)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboard.org

AUTHORIZATION AND RELEASE
LICENSED GENETIC COUNSELOR

To Whom It May Concern:

This document will authorize and direct any physicians with whom I have been associated; employees and staff members of any facility where I have been employed, on staff, or associated; any state medical licensing boards where I have been licensed or have applied for a license; any medical clinics where I have been employed or associated; and any schools where I have attended, to give to, copy for, or permit the personal inspection by employees or representatives of the Arkansas State Medical Board of any and all personnel records, disciplinary records, work records, military records, professional performance reviews, and/or evaluations of my performances.

I hereby release and discharge you and any other individuals or organizations referred to in this Authorization and Release of any confidentiality requirements that might bind you, and hereby release you from any and all liability or claims of any nature in connection with the information furnished to the Arkansas State Medical Board.

A copy of this Authorization and Release may be provided to each individual, hospital or organization where information concerning my credentials is sought and this Authorization and Release shall remain in effect until specifically revoked by me in writing.

Typed or Printed Name of Applicant: _____

Social Security Number: _____

Signature of Applicant: _____
Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: _____

ARKANSAS STATE MEDICAL BOARD

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ARKANSAS MEDICAL PRACTICES ACT and RULES AFFIDAVIT

Licensed Genetic Counselor

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE ANNOTATED § 17-95-1101, *et seq.*, AND THE RULES OF THE ARKANSAS STATE MEDICAL BOARD.

_____
Applicant's Full Name (First Middle Last, Suffix, Degree)

_____
Genetic Counselor's Signature (no rubber stamps)

_____
Signature Date

THIS IS A REQUIREMENT FOR LICENSURE.
YOUR LICENSURE APPLICATION WILL NOT BE PROCESSED WITHOUT THIS COMPLETED FORM.

ARKANSAS STATE MEDICAL BOARD

1401 West Capitol, Suite 340 ● Little Rock, AR 72201 ● (501) 296-1802 ● Fax (501) 296-1972
www.armedicalboard.org ● Support@armedicalboard.org
Email attachments must be in PDF format

THIS NOTIFICATION SHOULD BE DETACHED AND RETAINED BY APPLICANT

FINGERPRINTS SUBMITTED WITH THIS APPLICATION WILL BE USED TO CHECK FBI CRIMINAL RECORDS

NOTIFICATIONS FORM

To obtain a Copy of your FBI Criminal Record:
Procedures for obtaining a copy of FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.30 through 16.33 or go to the FBI website at http://www.fbi.gov/about-us/cjis/background-checks

Changes, Corrections, or Updating of Federal Criminal Record:
Procedures for obtaining a change, correction, or updating of an FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34 or go to the FBI website at http://www.fbi.gov/about-us/cjis/background-checks

If, after viewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wish changes, corrections, or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Service (CJIS) Division, and ATTN: SCU, Mod. D2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting the agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency

Appeal of Determination:
If your determination is based on an error such as wrong person, birth date, etc., please contact Health Facility Services Criminal History determination section at 501-661-2201. You may appeal a determination error within sixty (60) days by submitting a written request to: Health Facility Services Criminal History Appeals, 5800 W. 10th Street, #400, Little Rock AR 72204. Include your contact information and a description of the error.

Arkansas Code §A.C.A. 20-38-101

PRIVACY RIGHT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

APPLICANT TO REVIEW AND SIGN

- I HEREBY GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE AND THE FBI TO CONDUCT THE REQUIRED CRIMINAL RECORD CHECK ON MYSELF AND RELEASE ANY RESULTS TO THE LICENSING AUTHORITY AND THE STATE RESULTS TO THE QUALIFIED ENTITY
- I RECEIVED WRITTEN DIRECTIONS FOR CHANGES/CORRECTING/UPDATING MY FBI CRIMINAL RECORD
- I RECEIVED WRITTEN DIRECTIONS ON HOW TO OBTAIN A COPY OF MY FBI CRIMINAL RECORD
- I RECEIVED WRITTEN DIRECTIONS ALONG WITH THE TIME FRAME EXPLAINING HOW TO APPEAL THE ACCURACY/DISPOSITION INFORMATION

STATEMENT OF OATH:

I STATE ON OATH THAT THE REPRESENTATIONS MADE HEREIN ARE TRUE AND CORRECT.

THIS IS A REQUIREMENT FOR LICENSURE; YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT THIS COMPLETED FORM.

Printed name of applicant *Signature of applicant* *Date*

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
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Documents submitted by email must be sent in PDF format to support@armedicalboard.org

SECONDARY CONTACT DESIGNATION FORM

So that the licensing process might be made easier for both you and the Board, your Licensing Coordinator will communicate with you and ONE other person of your choice regarding the status of your licensure application. However, please advise your designated contact that your Licensing Coordinator is working with several other applicants at any given time, and that repeated phone calls to check on the status of your application will only delay the processing time for all applicants. We appreciate your consideration of this.

- This form is optional. If you do not choose to list a secondary contact designation, this form is not required.

I authorize the Arkansas State Medical Board to release any and all information regarding the status of my licensure application to the person listed below:

_____
Print full name of Secondary Contact

_____
Organization Name

_____
E-mail address of Secondary Contact

_____
Phone number of Secondary Contact

_____
Print full name of Applicant

_____
Signature of Applicant (no signature stamps)

_____
Date Signed

If you desire to utilize a secondary contact, this document must be completed and returned with your initial application. Information regarding your licensure application will not be released to anyone other than you without this written authorization. If you choose to utilize a designated contact, that person will be copied on all correspondence sent from this office regarding your application.

ARKANSAS STATE MEDICAL BOARD

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DATE OF REQUEST: .....

VERIFICATION OF GENETIC COUNSELOR EDUCATION

PART I – INSTITUTION NAME AND MAILING ADDRESS

Institution Name: .....
Department or Office: .....
Address Line 1: .....
Address Line 2: .....
City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX-_____	Date of Birth (mm/dd/yyyy) / /
Other Names Used		Date of Graduation (mm/dd/yyyy) / /
AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY DEAN, REGISTRAR or AUTHORIZED REPRESENTATIVE ONLY)

Please complete the information below (or your equivalent verification letter) and return **with an official transcript directly to the Arkansas State Medical Board.** Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Licensed Genetic Counselor Program (if not correct above)		
Date Education Began / /	Date Education Ended / /	Degree Awarded (ex: Master of Science in Genetic Counseling Studies) ❒ None
If program was not completed, or was completed in more or less than the customary time frame for such training, please provide explanation (use additional sheets if necessary)		
During this applicant's education, was he/she ever investigated or disciplined by the school for any reason? ❒ Yes ❒ No *[Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond "Yes" to this question, please provide a detailed explanation on a separate sheet, signed and dated by the person whose signature appears below.]*		

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name		Position/Title
Phone Number	Fax Number	E-mail Address

PLEASE RETURN THIS FORM WITH AN OFFICIAL TRANSCRIPT
DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: .....

VERIFICATION OF LICENSURE

PART I – LICENSING AUTHORITY NAME AND MAILING ADDRESS

Name of Licensing Authority: .....
ATTN: .....
Address Line 1: .....
Address Line 2: .....
City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX-_____	Date of Birth (mm/dd/yyyy) / /
Other Names Used		License Number for this state or country

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Applicant Signature (no electronic or stamped signature)	Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY LICENSING AUTHORITY STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

State/Country	Name of Licensing Authority (if not correct above)	
License Number	Original Issue Date (mm/dd/yyyy) / /	Expiration Date (mm/dd/yyyy) / /

Current License Status
❒ Active ❒ Inactive ❒ Temporary ❒ Other:_____

License Category
❒ Unlimited ❒ Educational ❒ Other:_____

Please answer the following questions and attach explanations and dates for any "Yes" answers.

Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction, or is any such investigation pending?	❒ Yes	❒ No
Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction, or is any such action pending?	❒ Yes	❒ No
Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state, or is any such action pending?	❒ Yes	❒ No

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name		Position/Title
Phone Number	Fax Number	E-mail Address

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
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Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

SUPERVISOR APPLICATION FOR A GENETIC COUNSELOR TEMPORARY LICENSE

☐ Adding new Supervisor ☐ Renewing Temporary License #_____

1. This form is to be filled out by the prospective Supervisor.
2. Type or print legibly (in dark blue or black ink). (one sided only)
3. All questions must be answered.

IMPORTANT INFORMATION

THE FOLLOWING ITEMS MUST BE INCLUDED WHEN SUBMITTING THIS APPLICATION:

1. **Supervisor Application.**
2. **Arkansas Medical Practices Act and Rules Affidavit signed by the Supervisor.**

*****Not sending these items together will result in a delay of the application process*****

LICENSED GENETIC COUNSELOR

Licensed Genetic Counselor Applicant's Full Name

SUPERVISOR

Supervisor's Name	AR License Number

Complete Practice or Office Address (PO Box or Street, City, State, Zip Code)

Office Telephone Number	Office Fax Number	Home Telephone Number	Mobile Telephone #

E-mail Address

CHECK ONE:

☐ Licensed Physician with American Board of Genetic Counseling Certification in clinical genetics
☐ Licensed Genetic Counselor

Type of Facility:

☐ Private Practice ☐ Clinic ☐ Hospital ☐ Other _____

_____ _____
Supervisor's Signature **Date Signed**

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
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Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AFFIDAVIT

(Supervisor)

I AFFIRM THAT I HAVE READ THE LICENSED GENETIC COUNSELOR ACT, ARKANSAS CODE 17-95-1101, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD. I UNDERSTAND A.C.A. § 17-95-1102 (3)(A) SAYS "SUPERVISION" MEANS THE ONGOING, DIRECT CLINICAL REVIEW FOR THE PURPOSES OF TRAINING OR TEACHING, BY AN APPROVED SUPERVISOR WHO MONITORS THE PERFORMANCE OR A PERSON'S SUPERVISED INTERACTION WITH A CLIENT AND PROVIDES REGULAR DOCUMENTED, FACE-TO-FACE CONSULTATION, GUIDANCE AND INSTRUCTIONS WITH RESPECT TO THE CLINICAL SKILLS AND COMPETENCIES OF THE PERSON SUPERVISED.

_____
Supervisor's Full Name (First Middle Last, Suffix, Degree)

_____
Supervisor's Signature (no rubber stamps)

_____
Signature Date

COUNTY OF _____
STATE OF ARKANSAS

Sworn to and subscribed before me this _____ day of _____, 20___.

_____
Notary Public

My Commission Expires: _____

ARKANSAS STATE MEDICAL BOARD
ATTN: LICENSURE DEPARTMENT
1401 WEST CAPITOL AVE, SUITE 340
LITTLE ROCK, AR 72201

ARKANSAS STATE MEDICAL BOARD

REGULATORY DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1805 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboard.org

TEMPORARY LICENSED GENETIC COUNSELOR SUPERVISION FORM

Applicants for Temporary Licensure are required to file a Supervision Form signed and dated by both the applicant and the Supervisor. It is the responsibility of the applicant to have the Supervision Form submitted with the Arkansas State Medical Board.

17-95-1108. Temporary licensure.

(a)(1) The Arkansas State Medical Board may issue a temporary license to an applicant who does not meet the certification requirement in *§ 17-95-1106 if the applicant:*

(A) Has been granted an active-candidate status by the American Board of Genetic Counseling;

(B) Applies for and takes the certification examination within twelve (12) months of the issuance of a temporary license; and

(C) Submits an application and appropriate application fees with the Arkansas State Medical Board.

(2) A temporary license is valid for one (1) year from the date of issuance.

(3)(A) A temporary license may be renewed for one (1) year if the applicant fails on his or her first attempt to pass the certification examination of the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics.

☐ Adding new Supervisor ☐ Renewing Temporary License #_____

☐ Removing_____ Date Supervision Ended _____
(Name of Supervisor) (For Former Supervisor)

LICENSED GENETIC COUNSELOR APPLICANT:

I certify that I have read and understand my responsibility to work in Arkansas only under the supervision of a Licensed Genetic Counselor. I agree to abide by the provisions of the Arkansas Medical Practices Acts and Regulations for Genetic Counselors.

Name of Applicant _____ Applicant's E-mail Address _____

Applicant's Signature _____ Signature Date _____ Date Supervision to Begin _____

SUPERVISOR:

As the GC Supervisor, I certify that I will provide supervision and consultation for the GC applicant named above as required in A.C.A. 17-95-1102 (3)(A-B).

Name of Supervising LGC or Physician _____ Supervisor's E-mail address _____

Name of Facility where supervision is to occur _____ Telephone No. _____

Address of Facility _____

Supervisor's Signature _____ Signature Date _____ Date Supervision to Begin _____

Supervisor's Arkansas License Number _____