OKLAHOMA STATE DEPARTMENT OF HEALTH

Instructions for Submitting an Application as a Licensed Genetic Counselor (LGC)

Below is a recommended sequence for completing your application for Licensed Genetic Counselor (LGC):

1. Obtain fingerprint cards from your local law enforcement agency or, **if that is not possible**, by contacting CHSLicensing@health.ok.gov with your name and mailing address.

2. Each applicant for licensure must have a background check completed by the Oklahoma State Bureau of Investigation (OSBI). Fingerprint cards take four (4) to six (6) weeks to process. The process time is determined by the OSBI and **cannot** be expedited by this office. Therefore, we thank you in advance for your patience.

3. Complete your part of the three Document of Recommendation forms and distribute them to the appropriate third parties, then retrieve the signed documents from the third party for submission to the Department.

4. Request that an **official copy of your university transcript** (graduate course work only), showing completion of your genetic counseling degree, be mailed to you from the university registrar. The transcript must be in a sealed envelope with the registrar's stamp over the flap. Include the unopened envelope from the registrar in your application packet.

5. Please be aware that transcripts cannot be reviewed and fingerprint cards cannot be processed unless you submit them, along with your application form and application fee.

6. Complete the application form and the license request form and affix the $300.00 license fee in the form of a personal check, money order, or cashier's check, payable to the "LGC Revolving Fund." Please do not mail cash.

7. Assemble all the above materials and submit them in one envelope to:

   Oklahoma State Department of Health
   Consumer Health Service
   PO Box 268815
   Oklahoma City, OK 73126-8815

If Applicable:

- Provide verification of active candidate status from the American Board of Genetic Counseling (ABGC).
- Provide verification of board certification from the ABGC or the American Board of Medical Genetics (ABMG).

Supervised Experience Forms:

Enclosed in your application packet is your supervision agreement. You may begin to document supervision hours only after you have made application and been approved by the Department. Review Section 1-565 (2) of the Act for professionals who qualify as supervisors. After submission, the OLS Director may approve the agreement and you can begin to practice under your temporary license.

For your own protection:

- Photocopy all the documents you have submitted.
- Submit your documents by certified mail.
- Double check – to ensure that all forms are completed as per instructions, transcript(s) are in a sealed envelope from the registrar and that all forms are signed and each signature is dated.

Failure to comply with the instructions may cause a delay in the processing of your application

APPLICATION INVENTORY - LGC

(Please attach this form to the front of your completed application packet)

Applicant's name: _____ Date: _____

Please check the line beside the appropriate response.

Inside this packet I have enclosed the following:

☐ Application form. ☐ The application fee, equaling: $ _____

☐ Sealed transcript. If yes, from which University(s)?

_____

☐ Three (3) documents of recommendation. If not three (3), then how many?: _____

Since three (3) recommendation forms are required, if less than three (3) are enclosed, please explain why:

_____

☐ Supervision Agreement. (If applicable at the time of application.)

☐ Verification of board certification from The American Board of Medical Genetics **or** verification of active candidate status from the American Board of Genetic Counseling.

☐ Affidavit of Lawful Presence

☐ License Request Form

☐ Two classifiable sets of fingerprints. (If fingerprint cards cannot be obtained through your local law enforcement agency, contact CHSLicensing@health.ok.gov)

Please list any additional enclosures in the space below:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Creating a State of Health

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Website: http://chs.health.ok.gov

APPLICATION FORM

Please check the license you are applying for:

☐ Licensed Genetic Counselor (LGC) ☐ Licensed Genetic Counselor – Temporary

Please type or print legibly:

Applicant's Name: _____

Social Security Number: _____ Birth date: _____ Sex: ☐ M ☐ F

Mailing Address: _____

City, State, Zip: _____

Area code & Telephone: _____

E-mail Address: _____

Current Place of Employment: _____

Telephone at Current Place of Employment: _____

Education: College/University granting the qualifying degree

(Please print out the full name of the school - do not abbreviate or use initials)

Name of Institution: _____

Location: _____

Degree Received: _____ Date of Graduation: _____ Specialty: _____

Name(s) on transcript(s) if different from that listed above:

_____

Other Credentials: If you possess professional licenses or certificates issued by Oklahoma or other states, give license or certificate titles, numbers, states issuing, and expiration dates:

_____

Professional Misconduct:

Have you ever had your professional membership, registration, certificate, or license suspended, revoked, restricted, or denied or has any other disciplinary action been taken against you by any professional organization, federal or state regulatory body or foreign jurisdiction, or are you presently under investigation by any regulatory body, to the best of your knowledge? ☐ **Yes** ☐ **No**

Have you ever had professional privileges in a hospital, HMO, etc., suspended or restricted or has any other disciplinary action been taken against you on grounds of unprofessional conduct, incompetence, negligence or unsafe practice? ☐ **Yes** ☐ **No**

Has any claim been made against you in a criminal or a civil suit or any other forum in the past ten years which clearly alleges unethical behavior on your part, including but not limited to the following examples: sexual intimacy with a patient, a dual relationship with a patient, violation of confidentiality, or any other offense which might relate to your professional practice? ☐ **Yes** ☐ **No**

Have you ever voluntarily given up privileges, registration, certificate or license to practice your profession or agreed to restrict your practice? ☐ **Yes** ☐ **No**

If you answered "Yes" to any of the four preceding questions, provide detailed information on a separate piece of paper.

Have you ever been convicted of a felony or a misdemeanor? ☐ **Yes** ☐ **No**

If your answer to the immediately preceding question is "Yes," please provide the following information:

Date of conviction: _____ Where convicted: _____

Charge: _____

If the conviction was set aside, give the date and provide detailed information on a separate piece of paper.

References:

Separate documents in your application packet call for recommendations from third parties. Three documents must be submitted. The rater must be **a professional** who is familiar with your **personal character** and **professional skills**. Do not request a person to act as a reference who is an employee of the Department of Health, a member of the Infant and Children's Health Advisory Council, or a member of your family.

Proposed Professional Practice:

Please describe how you plan to use your license including: 1.) type of professional setting (hospital, clinic, etc.)

2.) client population 3.) client age range 4.) type of practice (private not for profit, private for profit).

_____

_____

_____

_____

PLEASE READ CAREFULLY

I understand that the Oklahoma Open Records Act requires that all records contained in my licensing file, with the exception of my university transcripts and any documents associated with an on-going investigation of my professional conduct, are available for public scrutiny and photocopying. I hereby grant permission to the Department to seek any information or references deemed fit in securing my credentials pertinent to this application.

I further agree that if issued a license, upon the revocation of the license, I shall return said license. The information that I have provided in this application is truthful. I understand the giving the Department false information of any kind may result in the voiding of this application and possible disciplinary action.

I have read the Act and Regulations relevant to the license for which I am applying, understand them, and agree to abide by them.

_____ _____

Date Signature of Applicant

Oklahoma State Department of Health
Creating a State of Health

AFFIDAVIT OF LAWFUL PRESENCE
BY PERSON MAKING APPLICATION FOR A LICENSE, PERMIT OR CERTIFICATE

I, the undersigned applicant, being of lawful age, state that one of the following statements is true and correct: (Check only ONE of the following statements that apply)

☐ I am a United States citizen.

☐ I am an approved alien under the federal Immigration and Nationality Act and am approved to be present in the United States. **I understand this approval may or may not include approval for employment. The issuance of a license, permit or certificate by the Oklahoma State Department of Health is not authorization for employment in the United States.**

Admission/Registration #_____

Authorizing Document:_____ **(Attach a copy of the authorizing document.)**

I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct and that I have read and understand this form and completed it in my own hand.

Print Name: _____ Date: _____

City: _____ State: _____

Signature: _____

For RENEWAL license, permit or certificate, please write the number: _____
(Current license, permit or certificate number)

INSTRUCTIONS FOR USE OF THIS AFFIDAVIT OF LAWFUL PRESENCE FORM:
The person signing this form must read these instructions carefully.

1. If the person signing this form is receiving services and not making an application for a license, permit or certificate, this form should ***not*** be used but rather, either the form titled, "*Affidavit of Lawful Presence by Parent or Guardian of Person Receiving Services*" or the form titled "*Affidavit of Lawful Presence by Person Receiving Services*" should be used.

2. If the person signing this form is a citizen of the United States then that person should check the box to the left of the statement, "*I am a citizen of the United States.*" If the person signing this form is not a citizen of the United States but is an approved alien under the federal Immigration and Nationality Act and is lawfully present in the United States then that person should check the box to the left of the statement, "*I am an approved alien under the federal Immigration and Nationality Act and am approved to be present in the United States.*"

3. If an approved alien, write the identification number in the *"Admission/Registration #" field* and write the name of the authorizing document in the *"Authorizing Document"* field. (Examples of authorizing documents are: INS Form I-551 or INS Form I-94)

4. The person signing this form should write today's date in the space provided; write the city and state where they are actually located when they sign this form print and sign their name in the space provided; and if only if applying for a renewal write the current license, permit or certificate number in the space provided.

5. Within this form, the term "penalty of perjury" means the willful assertion of the fact of either United States citizenship or lawful presence in the United States as a qualified alien, and made upon one's oath or affirmation and knowing such assertion to be false. Making such a willful assertion on this form knowing it to be false is a crime in Oklahoma and may be punishable by a term of incarceration of not more than five (5) years in prison. Additionally, one who procures another to commit perjury is guilty of the crime of subornation of perjury and may be punished in the same manner, as he would be if personally guilty of the perjury so procured.

Oklahoma State Department of Health

Procedure for Initial License/Certification Applications

The Oklahoma State Department of Health (OSDH) participates in the Systematic Alien Verification for Entitlements (SAVE) Program, which is an intergovernmental information-sharing initiative designed to aid in determining a non-citizen applicant's immigration status (lawful presence), and thereby ensuring only U.S Citizens and eligible non-citizens receive government benefits, such as licenses. OSDH may only issue licenses, certifications or permits to Qualified Aliens (non-U.S. citizens) who present valid documentary evidence of one (1) of the following:

Alien Lawfully Admitted for Permanent Residence:

- **INS Form I-551** (Alien Registration Receipt Card, commonly known as a "green card"); or
- **Unexpired Temporary I-551**(Stamp in foreign passport or on INS Form I-94).

Immigrant or Non-Immigrant Visa Status:

- **INS Form I-94**
- **INS Form I-688B**

Asylee:

- **INS Form I-94** annotated with stamp showing grant of asylum under §208 of the INA;
- **INS Form I-688B** (Employment Authorization Card) annotated "27a .12 (a) (5)";
- **INS Form I-766** (Employment Authorization Document) annotated "AS";
- **Grant letter** from the Asylum Office of INS; or
- **Order** of an immigration judge granting asylum.

Refugee:

- **INS Form I-94** annotated with stamp showing admission under §207 of the INA;
- **INS Form I-688B** (Employment Authorization Card) annotated "274 a.12 (a) (3)";
- **INS Form I-766** (Employment Authorization Document) annotated "A3"; or
- **INS Form I-571** (Refugee Travel Document).

Alien Who Has Been Battered or Subjected to Extreme Cruelty:

INS petition and appropriate supporting documentation

Alien Paroled Into the U.S. for a least One Year:

- **INS Form I-94** with stamp showing admission for at least one year under §212 (d) (5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement.)

Alien Whose Deportation or Removal Was Withheld:

- **INS Form I-688B** (Employment Authorization Card) annotated "274 a.12 (a) (10)";
- **INS Form I-766** (Employment Authorization Document) annotated "A10"; or
- **Order** from an immigration judge showing deportation withheld under §243 (h) of the INA as in effect prior to April 1, 1997, or removal withheld under §241 (b) (3) of the INA.

Alien Granted Conditional Entry:

- **INS Form I-94** with stamp showing admission under §203 (a) (7) of the INA;
- **INS Form I-688B** (Employment Authorization Card) annotated "274 a.12 (a) (3)"; or
- **INS Form I-766** (Employment Authorization Document) annotated "A3".

Cuban/Haitian Entrant:

- **INS Form I-551** (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6;
- **Unexpired temporary I-551** stamp in foreign passport or on INS Form I-94 with the code CU6 or CU7; or
- **INS Form I-94** with stamp showing parole as "Cuba/Haitian Entrant" under § 212 (d) (5) of the INA.

Qualified Aliens: State law requires the Oklahoma State Department of Health to verify the immigration status (lawful presence) of all non-U.S. citizens upon initial license/certification and renewal.

QUALIFIED ALIENS MUST ATTACH A COPY OF THE DOCUMENTS that supports their status as shown above with their Affidavit of Lawful Presence. A license, permit, or certification **will not be issued until the appropriate documentation is submitted.**

Renewal applicants with new immigration documents are required to mail the new immigration documentation listed above to establish eligibility for renewal.

U.S. Citizens: After receipt of this Affidavit of Lawful Presence, U.S. Citizens are not required to attach an Affidavit of Lawful Presence every year.

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LGC DOCUMENT OF RECOMMENDATION

This document is to be completed by a **professional person** who has knowledge of the applicant's **personal character** and **professional competence**. Please rate the applicant in comparison to other professionals at a similar level of training and experience. Raters shall not be Health Department employees, members of the Board of Health, Advisory Council members, or members of the applicant's family.

(To be completed by applicant)

Applicant's Name: _____

Applicant's Address: _____

City, State, Zip: _____

Applicant's place of employment: _____

Applicant's telephone number: _____

(To be completed by rater)

Please rate the applicant in the following categories:

	No Observation	Below Average	Average	Above Average
Personal Character:	☐	☐	☐	☐
Professional Ethics:	☐	☐	☐	☐
Professional Training:	☐	☐	☐	☐
Assessment Skills:	☐	☐	☐	☐
Consulting Skills:	☐	☐	☐	☐
Research Skills:	☐	☐	☐	☐

Applicant's Name: _____

In the space below, you may add information regarding the applicant's fitness for licensure not heretofore addressed. If you have reservations regarding this applicant's fitness for licensure, please do not hesitate to include those concerns.

Rater's Name: _____

(Please print)

Circumstances under which you know the applicant: _____

_____

Dates you had professional contact with the applicant: From: _____ To: _____

Rater's organization: _____

Title/Position: _____

Telephone #: _____

Rater holds a license or certificate to practice as a: _____

Rater's Signature: _____ Date: _____

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(To be completed by applicant)

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Applicant's Address: _____

City, State, Zip: _____

Applicant's place of employment: _____

Applicant's telephone number: _____

(To be completed by rater)

Please rate the applicant in the following categories:

	No Observation	Below Average	Average	Above Average
Personal Character:	☐	☐	☐	☐
Professional Ethics:	☐	☐	☐	☐
Professional Training:	☐	☐	☐	☐
Assessment Skills:	☐	☐	☐	☐
Consulting Skills:	☐	☐	☐	☐
Research Skills:	☐	☐	☐	☐

Applicant's Name: _____

In the space below, you may add information regarding the applicant's fitness for licensure not heretofore addressed. If you have reservations regarding this applicant's fitness for licensure, please do not hesitate to include those concerns.

Rater's Name: _____

(Please print)

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_____

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Rater's Signature: _____ Date: _____

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(To be completed by applicant)

Applicant's Name: _____

Applicant's Address: _____

City, State, Zip: _____

Applicant's place of employment: _____

Applicant's telephone number: _____

(To be completed by rater)

Please rate the applicant in the following categories:

	No Observation	Below Average	Average	Above Average
Personal Character:	☐	☐	☐	☐
Professional Ethics:	☐	☐	☐	☐
Professional Training:	☐	☐	☐	☐
Assessment Skills:	☐	☐	☐	☐
Consulting Skills:	☐	☐	☐	☐
Research Skills:	☐	☐	☐	☐

Applicant's Name: _____

In the space below, you may add information regarding the applicant's fitness for licensure not heretofore addressed. If you have reservations regarding this applicant's fitness for licensure, please do not hesitate to include those concerns.

Rater's Name: _____

(Please print)

Circumstances under which you know the applicant: _____

_____

Dates you had professional contact with the applicant: From: _____ To: _____

Rater's organization: _____

Title/Position: _____

Telephone #: _____

Rater holds a license or certificate to practice as a: _____

Rater's Signature: _____ Date: _____

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LGC SUPERVISION AGREEMENT

Section 1-565 (2) of the Genetic Counseling Licensure Act states, "An individual practicing under the authority of a temporary license must practice under the general supervision of a licensed genetic counselor, or a physician licensed to practice in this state, with current ABMG certification in clinical genetics."

Subchapter 310:406-13-2 of the LGC Regulations states, "All individuals practicing under the authority of a temporary license shall receive general supervision as required by the Act. Supervision shall at a minimum include a review of applicable genetic counseling services provided by the supervisee that have not been previously reviewed."

The Regulations also include the following requirements:

1) an approved supervisor
2) supervision agreement must be submitted annually and may be renewed annually
3) supervision agreement must be approved by the Department prior to starting supervision
4) supervision contact shall occur at least every two weeks
5) documentation of supervision form must be submitted annually

This supervision agreement must be completed and submitted to the Occupational Licensing office and approved by the office before the temporary licensee can begin supervision.

I, the undersigned, have read and agree to comply with the requirements set forth in Section 1-565 (2) of the Genetic Counseling Licensure Act and Subchapter 13 of the LGC Regulations.

	TEMPORARY LICENSEE	**SUPERVISOR**
Print name:	_____	_____
Place of Employment:	_____	_____
Street Address:	_____	_____
City, State, Zip:	_____	_____
Phone:	_____	_____
Date:	_____	_____
Signatures:	_____	_____

IF THIS IS A RENEWAL FOR SUPERVISION, THIS FORM WILL NOT BE APPROVED IF NOT ACCOMPANIED BY DOCUMENTATION OF SUPERVISION FORM FROM PREVIOUS YEAR.

(For office use only)

Date approved: _____ OLS Staff approving: _____

Date disapproved: _____ Reason for disapproval: _____

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LGC DOCUMENTATION OF SUPERVISION

Note to supervisor: Information given on this form is for this **twelve-month interval only**. When the evaluation form is completed, review it with your supervisee. The majority of complaints received in our office involve dual relationships and breaches of confidentiality. Please emphasize these ethical considerations to your supervisee.

Note to temporary licensee: If you are documenting experience at more than one setting or with more than one supervisor, submit evaluations for each setting separately and submit more than one supervision agreement if necessary.

Name of Temporary Licensee: _____

Name of Supervisor: _____

Name of Place of Supervision: _____

Address of Place of Supervision: _____

City, State, Zip: _____

Dates of supervision this twelve-month period: From: _____ To: _____

Describe the types of patients seen by temporary licensee at the current setting:

Supervisor comments:

LGC DOCUMENTATION OF SUPERVISION LOG

(This page should always accompany the Documentation of Supervision Form)

Make copies of this page as needed.

Temporary Licensee's Name (please print): _____

Supervisor's Name (please print): _____

Date Supervision Agreement was approved by the Department: _____

WORK WEEK BEGINNING DATE:	DATE(S) MET WITH YOUR SUPERVISOR	COMMENTS

TEMPORARY LICENSEE'S SIGNATURE: _____ **Date:** _____

SUPERVISOR'S SIGNATURE: _____ **Date:** _____

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LICENSE REQUEST FORM

Please check the appropriate license:

☐ **Licensed Genetic Counselor (LGC)** ☐ **Licensed Genetic Counselor – Temporary**

NAME AND INITIALS OF ONE GRADUATE DEGREE

(name listed below should not exceed 26 characters, including punctuation and spaces)

_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_

Applicant Signature: _____ Date: _____

******For Office Use Only******

License #: _____

Issue Date: _____

Expiration Date: _____