IOWA BOARD OF MEDICINE
400 S.W. 8th Street Suite C, Des Moines, Iowa 50309-4686
Phone: 515-281-6641 | Fax: 515-242-5908 | Email: licensure@iowa.gov

Application for Genetic Counselor & Provisional Genetic Counselor License

Instructions

- Follow the instructions in each section of the application.
- Do not leave any section of the application blank. If a section or an item within the section does not pertain to you, indicate that it is not applicable by placing an "NA" in the section or item.
- Use the checklist on the last page when reviewing the application.
- For additional space to complete any section, attach a separate sheet of paper labeled with the appropriate section number. Sign and date each attached sheet.

1. Application for (check one):

◯ **Genetic Counselor licensure.** Application Fee: $245

◯ **Provisional Genetic Counselor licensure**. Application Fee: $245
(*Provisional licenses will be transitioned to a genetic counselor license upon receipt of certification verification directly from the ABGC or ABMGG.*)

2. Identifying Information:

Enter your full legal name, including your full middle name (if applicable). Your license will be issued in your full legal name.

Legal Name

First: _____ Middle: _____ Last: _____ Suffix: _____

Aliases or nicknames, if any: _____

Maiden name, if any: _____

Personal/Home Contact Information

Street: _____ Apt./Unit: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ Email: _____

Work Contact Information

Employer/company name: _____

Street: _____ Suite: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ Email: _____

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Preferred Mailing Address. Select the address to which you prefer to receive correspondence from the Iowa Board of Medicine. Only your work address will be displayed on our website with your license information.

◯ Home ◯ Work

Are you a United States Citizen? ◯ Yes ◯ No

Social Security Number _____

Birth Information

Birthdate (MM/DD/YYYY): _____ City of Birth: _____

State of Birth: _____ Country of Birth: _____

3. Professional and Employment History

List below, in chronological order, your professional and employment history since enrolling in a genetic counselor degree program, including periods of unemployment for 30 days or more. Provide any relevant hospital or clinic affiliation information. Attach additional sheets if necessary.

- Include exact nature, location, and length of each activity.
- Do not estimate dates. Verify any dates you are unsure of and enter the exact dates below.
- Explain any period of unemployment or absences from training exceeding 30 days that is entered below (examples include extended vacations, medical or personal leave, etc.).

Activity	Location (City, State/ Province/Territory)	From (MM/YY)	To (MM/YY)

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4. Genetic Counselor License Information

List, in chronological order, any type of genetic counselor license, registration, or provisional license you have ever held in the United States or Canada. Do not estimate licensure information; verify any information of which you are unsure. Attach additional sheets if necessary.

State/Province/ Territory, Country	License Type	License Number	License Status	Original Issue Date (MM/YY)

5. Other Professional License Information

Do you currently hold or have you ever held any other professional licenses from the United States or Canada? ◯ Yes ◯ No

If yes, provide the following information for each professional license. Attach additional sheets if necessary.

State/Province/ Territory, Country	License Type/Profession	License Number	License Status	Original Issue Date (MM/YY)

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6. Certification Information

To receive a genetic counselor license or provisional genetic counselor license in Iowa, you must currently be certified by the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics.

Check the appropriate option below and provide the requested information. *As part of this application, you must request that a letter confirming your certification from the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics be mailed or emailed directly to the Iowa Board of Medicine. Attach additional sheets if necessary.*

◯ **For Genetic Counselor License Applicants:** I have evidence of active certification as one of the following:
- Genetic counselor by the American Board of Genetic Counseling
- Genetic counselor by the American Board of Medical Genetic and Genomics
- Medical geneticist by the American Board of Medical Genetics and Genomics

◯ **For Provisional Genetic Counselor License Applicants:** I hold active candidate status by the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics.

Title	Certifying Body	Certificate Number	Issue Date (MM/YY)	Expiration Date (MM/YY)

7. Practice Information

Describe your proposed Iowa practice. If unknown at this time, please explain:

_____

_____

_____

_____

Proposed Iowa Practice Address:

Institution/Group:_____

Street: _____Suite: _____

City:_____ State: _____ ZIP:_____

Anticipated Start Date (MM/YYYY): _____

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Definitions

Review the definitions below before completing Section 8, Questionnaire.

"***Ability to practice genetic counseling with reasonable skill and safety***" means the ability to do all of the following:

- Obtain and evaluate individual, family, and medical histories to determine genetic risk for genetic and medical conditions and diseases in a patient, the patient's offspring, and other family members;
- Discuss the features, history, means of diagnosis, genetic and environmental factors, and management of risk for genetic and medical conditions and diseases;
- Identify, order, and coordinate genetic laboratory tests and other diagnostic studies as appropriate for the genetic assessment of a patient;
- Refer a patient to a specialty or subspecialty department as necessary for the purpose of collaborating on diagnosis and treatment involving multiple body systems and general medical management;
- Integrate genetic laboratory test results and other diagnostic studies with personal and family medical history to assess and communicate risk factors for genetic and medical conditions and diseases;
- Explain the clinical implications of genetic laboratory tests and other diagnostic studies and their results;
- Evaluate the responses of a patient or patient's family to the condition or risk of recurrence and provide patient-centered genetic counseling and anticipatory guidance;
- Identify and utilize community resources that provide medical, educational, financial, and psychosocial support and advocacy; and
- Provide written documentation of medical, genetic, and counseling information for families and health care professionals.

"***Medical condition***" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"***Chemical substances***" means alcohol and legal and illegal drugs or medications, including medications taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"***Currently***" means the medical condition has an ongoing or adverse impact on the ability to function and practice.

"***Improper use of drugs or other chemical substances***" means any of the following:

- The use of any controlled drug, prescription drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner.
- The use of any substance, including but not limited to petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"***Illegal use of drugs or other chemical substances***" means the manufacture, possession, distribution, or use of any chemical substances prohibited by law (e.g. heroin).

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8. Questionnaire

Instructions. You must complete every question. The Board expects full disclosure of events whether you consider them to be minor or major in nature. Failure to disclose information in this application may result in disciplinary action, up to and including denial of your application or revocation of an existing license.

If you respond "yes" to **any** question, you **must** provide a detailed explanation of your response on a separate sheet of paper. Label each explanation with the appropriate section and question number and sign and date each additional attached sheet. This statement must provide all relevant details, including dates, locations, actions, organizations, and parties involved. You must also provide the requested supporting documentation. The Board may request additional supporting information.

Current IPHP participants may answer "No" to questions 1 through 5.

Questions:

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice with reasonable skill and safety? If yes, provide a description of your condition and submit the "Verification of Medical Condition" form on pages 14-15 of this packet, which is to be completed by your treating physician(s).

   ◯ YES ◯ NO

2. Are you receiving ongoing treatment or participating in a monitoring program that reduces, or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances? If yes, provide details of your treatment or program, copies of treatment evaluations, and a statement from the program indicating your progress and practice recommendations.

   ◯ YES ◯ NO

3. *If you answered "NO" to questions 1 and 2, Answer "NO" to this question. If you answered "YES" to question 1 or 2*: Does your field of practice, or the setting or the manner in which you have chosen to practice genetic counseling, reduce or eliminate the limitations or impairments caused by your medical condition or use of alcohol, drugs or other chemical substances? If yes, provide a description of your practice and how it has changed since the diagnosis of your medical condition.

   ◯ YES ◯ NO

4. Are you currently engaged in the illegal or improper use of drugs or other chemical substances? If yes, provide an explanation.

   ◯ YES ◯ NO

5. Does your current use of alcohol, drugs, or other chemical substances in any way impair or limit your ability to practice genetic counseling with reasonable skill and safety? If yes, explain your current usage and how this impairs your ability to practice.

   ◯ YES ◯ NO

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6. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.) Driving under the influence or driving while impaired is not a minor traffic offense. If yes, provide details about the charge(s) and the final outcome of each incident. Provide copies of any court/legal documents related to each incident.

   ◯ YES ◯ NO

7. During your genetic counseling graduate education, were you ever terminated, requested to withdraw, asked to repeat training or education, given a warning, asked to participate in remediation, or placed on probation? If yes, provide an explanation.

   ◯ YES ◯ NO

8. Have you ever taken a leave of absence for any reason (maternity, family, personal, financial, military service, research, study for board certification exam, etc.) during your education? If yes, provide an explanation.

   ◯ YES ◯ NO

9. Have you ever been denied a license to practice genetic counseling or a license to practice any other profession? If yes, provide an explanation and a copy of the notice of denial.

   ◯ YES ◯ NO

10. a. Have you ever surrendered any professional license for any reason? If yes, provide an explanation and a copy of all official documents relating to the surrender. If no, skip to question 11.

    ◯ YES ◯ NO

    b. If yes, was a license disciplinary action pending against you or were you under investigation by a professional licensing agency at the time you surrendered the license? If yes, provide an explanation and a copy of all related official documents.

    ◯ YES ◯ NO

11. Have your affiliations with or staff status at any hospital or health care entity, clinic, or other professional health care organization ever been limited, suspended, revoked, not renewed, voluntarily relinquished, denied, or subjected to other disciplinary or probationary conditions? If yes, provide an explanation and a copy of all related official documents.

    ◯ YES ◯ NO

12. Have you ever been terminated, sanctioned, penalized, required to repay monies to, or been denied provider participation in Medicaid, Medicare, or any other publicly funded healthcare program? If yes, provide an explanation and a copy of all related official documents.

    ◯ YES ◯ NO

13. Have you ever been denied membership or renewal, or been subject to any disciplinary action, sanction, or warning, in any organization or professional society? If yes, provide an explanation and a copy of all related official documents.

    ◯ YES ◯ NO

14. Have you ever been investigated or subject to an inquiry/review by any professional licensing agency, including investigations or reviews which resulted in no formal action? (Answer "Yes" if you have ever been contacted by an investigator or Board agent to review a complaint or report filed against you.) If yes, provide an explanation of the inquiry, including dates, state, charges, final outcome and a copy of all related official documents.

    ◯ YES ◯ NO

15. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked, or filed charges against any license, certificate, or registration you have held? If yes, provide an explanation and a copy of all related official documents.

    ◯ YES ◯ NO

16. Are you in violation of any child support order or written agreement to pay child support? If yes, provide an explanation.

    ◯ YES ◯ NO

17. Have any professional liability lawsuits ever been filed against you? If yes, complete the attached Professional Liability Suit Information form on page 16 of this packet along with a copy of the requested legal documents listed on that form.

    ◯ YES ◯ NO

18. Have any judgments or settlements been paid on your behalf as a result of a professional liability case? If yes, complete the attached Professional Liability Suit Information form on page 16 of this packet along with a copy of the requested legal documents listed on that form.

    ◯ YES ◯ NO

Signature: _____ Date (MM/DD/YYYY): _____

Iowa Physician Health Program (IPHP)

The IPHP is a confidential, voluntary program offered to licensed genetic counselors who may be dealing with impairment issues, such as, but not limited to alcohol or drug abuse, dependency or addiction, neuropsychiatric disorder, or physical disability. The IPHP develops an individualized program for each licensee, with the goal of allowing the genetic counselor to continue to practice with reasonable skill and safety.

Oftentimes, the Licensure Committee of the Board will refer physicians and genetic counselors with impairment issues to the IPHP for review and bases licensure decisions on its recommendations.

To self-report to the IPHP or obtain additional information, contact the Coordinator of IPHP at 515-281-6006.

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Additional Sheet(s)

Use this page as needed for additional space to complete any section of this application. Label each response with the appropriate section/question number. Sign and date all copies of this sheet.

Signature: _____ Date (MM/DD/YYYY): _____

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Genetic Counselor & Provisional Genetic Counselor Licensure Checklist

Keep this page and use the checklist to ensure that your application is complete. Contact the Licensure Division at 515-281-6641 or Licensure@Iowa.gov if you have questions or concerns.

Once your application has been reviewed, you will receive an e-mail updating you as to the status of your application. When your application is approved, we will send you a background check packet to complete. The background check packet must be returned to the Board and verified before your license may be issued.

1. Submit the following items to the Board as part of your application for licensure. Applications and supporting documents must be mailed to: Iowa Board of Medicine, 400 SW 8th Street, Ste. C, Des Moines, IA 50309.

   ◯ **Application & Fees:** Complete the application and mail it along with the $245 application fee to the Board's address listed above. Check or money order must be made payable to the Iowa Board of Medicine.

   ◯ **Affidavit & Authorization for Release of Information:** Complete the form on page 11 of this packet and submit it with your application. This form must be signed and notarized in the physical presence of a notary; electronic notarization is not accepted. You may use this form as a release for other required forms, such as the verification of medical condition form.

   ◯ **Supporting Documentation & Additional Pages:** If you answered "yes" to any of the questions in section 8 of this application, or you included additional pages, ensure all supporting documentation and additional pages are enclosed with your application.

   ◯ **Additional Required Forms:** If you answered “yes” to any of the questions identified below, you must submit with your application the completed forms from this packet, as indicated below:
   - Question 1: ***Verification of Medical Condition*** form on pages 14-15.
   - Questions 17 or 18: ***Professional Liability Lawsuit Information*** form on page 16.

2. Submit the following items to the appropriate licensing or certifying body.

   ◯ **Verification of U.S. or Canadian Genetic Counselor or Professional License(s):** Complete the form on page 12 of this packet and send to all licensing bodies listed in section 4 of this application. Make copies of page 12 as needed. Verification is required regardless of current status.

   ◯ **Verification of ABGC or ABMGG Certification:** You must request a verification of your ABGC or ABMGG Certification. You may make this request using page 13 of this packet or any other means accepted by ABGC or ABMG.

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(515) 281-6641 www.medicalboard.iowa.gov

Affidavit and Authorization for Release of Information

Applicant: Sign this form in the physical presence of a notary public with an attached passport-quality color photo. **Mail this form directly to the Iowa Board of Medicine, 400 SW 8th Street, Suite C, Des Moines, IA 50309.**

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in the application for licensure in Iowa, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the application for licensure and I have personally answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, medical records, or any other pertinent data, and to permit the 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.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice as a genetic counselor is granted to me by the Board.

I understand I am responsible for completing my own application for licensure in Iowa. My failure to complete my own application, failure to answer questions contained in the application truthfully and completely, or failure to sign this document in the physical presence of a notary may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice genetic counseling.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front- view 2" x 2" passport-quality color photo of yourself in this square.

_____

Applicant's signature (must be signed in the physical presence of a notary. Notarization via webcam or any other method is not allowed.)

_____

Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____

Date of signature (must correspond to date of notarization)

NOTARY

Please note: The Notary Public seal should overlap the bottom of the photo to the left.

State of_____, County of_____,

I certify that on the date set forth below, the individual named above did appear physically before me and that I did identify this applicant by: (a) comparing his/her appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this ____ day of_____, 20_____.

Notary Public Signature_____My Notary Commission Expires _____

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Verification of Genetic Counselor License, Registration & Other Professional License(s)

Applicant: Complete the top portion of this form and submit to each regulatory agency that has issued you a genetic counselor license/registration or any other professional license.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

Verifying Regulatory Agency: Complete and return the form directly to the Iowa Board of Medicine. In lieu of completing the form, the requested information can be provided on the agency's official letterhead. Any processing fees are the applicant's responsibility.

It is hereby certified that _____
(Name of Applicant)

Was issued license/registration/certification number_____
(Number Issued)

On _____ By: _____
(Issue Date) (Issuing State Agency)

Expiration date of license/registration/certification number _____
(Expiration Date)

Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? ○ YES ○ NO
If yes, *provide details of the disciplinary action and a copy of any documentation related to the event.*

Are there any pending complaints against this applicant's license? ○ YES ○ NO
If yes, *provide details of the pending complaints and a copy of any documentation related to the event.*

Has the applicant voluntarily relinquished their credential? ○ YES ○ NO
If yes, *provide a letter of explanation.*

Institutional Seal

(If your institution does not have an official seal, this form must be notarized.)

Completed by the Regulatory Agency for the Credential:

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

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Verification of ABGC or ABMGG Certification

Applicant: Complete the top portion of this form and submit to the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics to verify your certification status.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

Verifying Regulatory Agency: Complete and return the form directly to the Iowa Board of Medicine. In lieu of completing the form, the requested information can be provided on the agency's official letterhead. Any processing fees are the applicant's responsibility.

It is hereby certified that _____
(Name of Applicant)

Was issued certification on _____
(Issue Date)

Expiration Date _____
(Expiration Date)

Has any disciplinary action been taken against this applicant's certification status?

◯ YES ◯ NO

If yes, *provide details of the disciplinary action and a copy of any documentation related to the event.*

Are there any pending complaints against this applicant's certification status?

◯ YES ◯ NO

If yes, *provide details of the pending complaints and a copy of any documentation related to the event.*

Institutional Seal

(If your institution does not have an official seal, this form must be notarized.)

Completed by the Certifying Agency:

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

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Verification of Medical Condition

Applicant: Complete the top portion of this form. You are required to provide a statement explaining any medical condition you have experienced that has had an ongoing or adverse impact on your ability to function and practice.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

The remainder of this form must be completed by the physician who diagnosed and/or provides or provided treatment for the condition.

Treating Physician: Complete and mail the form directly to the Iowa Board of Medicine. This form is also on our website as a pdf document which can be completed using a computer and printing the document. The authorization of release of information included herein authorizes the release of information, favorable or otherwise, directly to the Board.

Applicant's name (print legibly): _____

Applicant's date of birth (MM/DD/YYYY): _____

Nature of Medical Condition (include specific diagnosis): _____

_____

_____

_____

Summary of Treatment: _____

_____

_____

_____

Treatment Period: From (MM/DD/YYYY)_____ **To** _____

Recommended Treatment:_____

_____

_____

_____

Is/Was the Applicant in compliance with their treatment? ○ Yes ○ No

If "no," please explain:

_____

_____

_____

Is the Applicant taking any prescribed medications? ○ Yes ○ No

If yes, please list the medication(s):

_____

_____

_____

Provide a summary of other prescription medications the Applicant is taking:

_____

_____

_____

Has this medical condition in any way affected the Applicant's ability to practice genetic counseling? ○ Yes ○ No

If yes, please explain:

_____

_____

_____

Do any limitations need to be in place with regard to the Applicant's practice of genetic counseling? ○ Yes ○ No

If yes, please explain:

_____

_____

_____

Is ongoing monitoring warranted? ○ Yes ○ No

If yes, please explain:

_____

_____

_____

Treating Physician Information:

Name (print legibly): _____

Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

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Professional Liability Lawsuit Information

Applicant: Complete this form for each lawsuit in which you have been named a party that involves your practice of genetic counseling. Summaries of this information from insurance carriers is not acceptable. Submit the requested documentation for each suit. Provide responses on additional sheets if necessary.

Name of Plaintiff(s)/Patient(s): _____

Date of Incident giving rise to the lawsuit (MM/DD/YYYY): _____

Date lawsuit was filed (MM/DD/YYYY): _____

Status of the Lawsuit. Indicate the status of the lawsuit and provide requested documents and information.

- ◯ **Pending.** Submit a copy of the complaint and a letter from your attorney indicating the status of the case.
- ◯ **Dismissed.** Submit a copy of the dismissal order.
- ◯ **Settled.** Submit a copy of the complaint, final disposition, and settlement agreement/release.
  Amount settled on your behalf: $_____
- ◯ **Other:** _____

What was your role in the lawsuit/claim?: Primary Defendant Co-defendant Other: _____

Did the lawsuit involve a patient death, wrong-sided surgery, or loss of limb/major organ?: ◯ Yes ◯ No

Describe the allegations/claims against you:

_____

_____

_____

_____

_____

Describe your involvement in the care of the patient:

_____

_____

_____

_____

_____

Applicant Name (Print): _____

Applicant Signature: _____ **Date (MM/DD/YYYY):** _____