

OKLAHOMA STATE DEPARTMENT OF HEALTH

Instructions for making application as a Licensed Genetic Counselor (LGC)

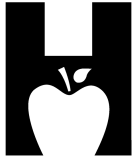
SUBMISSION OF APPLICATION: Your application for licensure must be returned by mail* to the Professional Counselor Licensing Division in packet form. This means that all forms and university transcript(s) **must be submitted together in one envelope**. Below is a recommended sequence for completing your application:

1. Study the Act and Regulations included in your materials. These documents describe the particulars of your application and direct your professional behavior as a licensee. You may download a copy at www.health.ok.gov/program/lpc
2. Request fingerprint cards from the office of Professional Counselor Licensing by contacting Carolyn Martin at CarolynKM@health.ok.gov with your name and mailing address.
3. Complete your part of the three documents of recommendation and distribute them to the appropriate third parties, **then retrieve the signed documents from the third party for submission to the Department.**
4. University transcript – **request that an official** copy of your transcript 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. If applicable, provide verification of active candidate status from the American Board of Genetic Counseling (ABGC).
6. If applicable, provide verification of board certification from the ABGC or the American Board of Medical Genetics (ABMG).
7. Complete the application form and the license request form.
8. For your own protection:
 - A. Photocopy all the documents you have submitted.
 - B. Submit your documents by certified mail.
 - C. 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. Failure to comply with the instructions will cause a delay in the processing of your application.
9. Assemble all the above materials and submit them in one envelope to:

Professional Counselor Licensing
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th Street
Oklahoma City, OK 73117-1299

DOCUMENTATION OF SUPERVISION: 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 PCL Director may approve the agreement and you can begin to practice under your **temporary license**.

***Facsimile or other electronic submission of documents will not be accepted.**



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Protective Health Services
Professional Counselor Licensing
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Telephone: (405) 271-6030
FAX: (405) 271-1918
www.health.ok.gov/program/lpc

APPLICATION FORM

Please check the license you are applying for:

- Licensed Genetic Counselor (LGC) Licensed Genetic Counselor -Temporary

(Please Print or Type Legibly)

1. Identifying Information:

- a) Applicant's Name: _____
- b) Social Security Number: _____ c) Birth date: _____ d) Sex: M F
- e) Preferred Mailing Street Address: _____
- f) City, State, Zip: _____
- g) Area code & Telephone: _____
- h) E-mail Address: _____
- i) Current Place of Employment: _____
- j) Telephone at Current Place of Employment: _____

2. Education: College/University granting the qualifying degree
(Please print out the full name of the school - do not abbreviate or use initials)

- a) Name of Institution: _____
- b) Location: _____
- c) Degree Received: _____ d) Date of Graduation: _____ e) Specialty: _____
- f) Name(s) on transcript(s) if different from that listed on item 1(a) of this application:

3. 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 date.

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4. Professional Misconduct:

a) 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

b) 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

c) 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

d) 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 above, provide detailed information on a separate piece of paper.

e) Have you ever been convicted of a felony or a misdemeanor?

Yes No

f) If your answer to number 4.(e) 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.

5. 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 Board of Health or the LPC, LMFT, or LBP Advisory Boards, a member of the Genetic Counseling Advisory Committee or a member of your family.

6. 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

NOTARIZATION

The State of _____)
County of _____)

BEFORE ME, the undersigned authority, on this day personally appeared _____
known to me to be the person whose name is subscribed to the foregoing instrument, and having been by me first duly sworn on oath,
acknowledged that he had executed the same for the purposes and considerations therein expressed and that the foregoing statements
are true and correct.

GIVEN under my hand and seal of office, this _____ day of _____, _____.

My commission expires _____, _____.

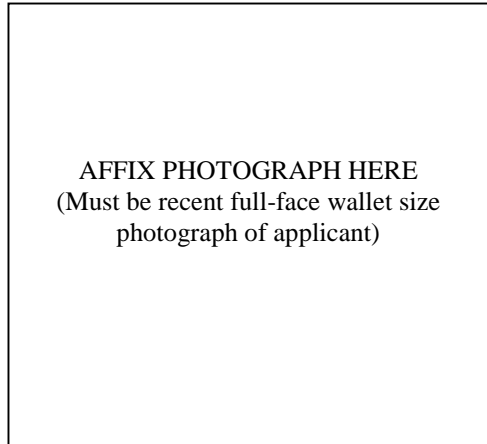
Notary Public in and for _____ County, Oklahoma or _____.
(Please place notary seal on edge of photograph.)

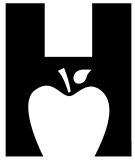
Name of Notary

Signature of Notary

Return to:
Oklahoma State Department of Health
Protective Health Services
Professional Counselor Licensing
1000 N.E. 10th Street
Oklahoma City, OK 73117-1299

E-mail: nenaw@health.ok.gov
Web address: www.health.ok.gov/program/lpc





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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 or members of the Board of Health or Advisory Committee or members of the applicant's family.

(To be completed by Applicant)

Applicant's Name: _____

Applicant's Address: _____

Applicant's place of employment: _____

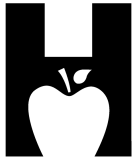
Applicant's telephone number: _____

(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:	_____			

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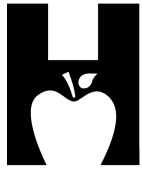
Applicant's telephone number: _____

(To be completed by rater)

Please rate the applicant in the following categories:

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Personal Character:	_____	_____	_____	_____
Professional Ethics:	_____	_____	_____	_____
Professional Training:	_____	_____	_____	_____
Assessment Skills:	_____	_____	_____	_____
Consulting Skills:	_____	_____	_____	_____
Research Skills:	_____	_____	_____	_____

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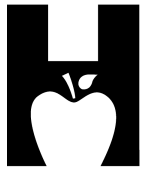
Applicant's telephone number: _____

(To be completed by rater)

Please rate the applicant in the following categories:

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Personal Character:	_____	_____	_____	_____
Professional Ethics:	_____	_____	_____	_____
Professional Training:	_____	_____	_____	_____
Assessment Skills:	_____	_____	_____	_____
Consulting Skills:	_____	_____	_____	_____
Research Skills:	_____	_____	_____	_____

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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 Professional Counselor 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:

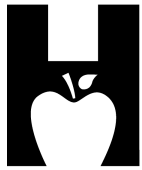
Signatures:

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

-----**(For office use only)**-----

Date approved: _____ PCL 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 and Address of place of supervision: _____

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

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

Supervisor comments:

Supervisor signature: _____ **Date:** _____

Temporary Licensee signature: _____ **Date:** _____

