Creating a State of Health

PROTECTIVE HEALTH SERVICES

Oklahoma State Department of Health
Protective Health Services
Occupational Licensing
Licensed Genetic Counselors
Mail: PO Box 268815, Oklahoma City, OK 73126-8815
Physical: 1000 NE 10th Street, Oklahoma City, OK 73117
Phone: (405) 271-5779 // Fax: (405) 271-5286
Website: http://old.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