



**PROTECTIVE
HEALTH
SERVICES**

Oklahoma State Department of Health

Protective Health Services
Occupational Licensing

Licensed Genetic Counselors

Mail: PO Box 268817, Oklahoma City, OK 73126-8817

Physical: 1000 NE 10th Street, Oklahoma City, OK 73117

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Website: <http://old.health.ok.gov>

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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Ethics:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Training:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment Skills:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consulting Skills:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Research Skills:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____