

# Application for Genetic Counselor



Department of Health  
Genetic Counseling  
P.O. Box 6330

Tallahassee, FL 32314-6330

Website: <http://www.floridahealth.gov/licensing-and-regulation/genetic-counseling/index.html>

Email: [MQA.GeneticCounseling@flhealth.gov](mailto:MQA.GeneticCounseling@flhealth.gov)

Phone: (850) 245-4292

Fax: (850) 413-6982

DH-MQA 5067, 7/2022 Rule 64B34-1.001



**Are you an active duty member of the United States Armed Services?**

**Are you a veteran of the United States Armed Services?**

**Are you the spouse of a veteran of the United States Armed Services?**

**Are you the spouse of an active member of the United States Armed Services?**

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at

<http://www.flhealthsource.gov/valor>





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Do Not Write in this Space  
For Revenue Receiving Only

**Genetic Counselor (1020) - \$5.00**

**Upgrade from Temporary License (1025)**

**Total fee of \$5.00 includes the following:**

Unlicensed Activity Fee (refundable) \$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Certain fees are refundable for up to three years from the date of receipt.

## 1. PERSONAL INFORMATION

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
Last/Surname First Middle MM/DD/YYYY

**Mailing Address:** (The address where mail and your license should be sent)

Street/P.O. Box Apt. No. City

State ZIP Country Home/Cell Telephone (Input without dashes)

**Physical Location:** (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

Street Suite No. City

State ZIP Country Work/Cell Telephone (Input without dashes)

### EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: Male Race: Native Hawaiian or Pacific Islander Hispanic or Latino White  
Female American Indian or Alaska Native Black or African American Asian  
Two or More Races

**Email Notification:** To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the Department of Health.

Yes No Email Address: \_\_\_\_\_

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

## 2. SOCIAL SECURITY DISCLOSURE

**This information is exempt from public records disclosure.**

Pursuant to Title 42 United States Code § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

**Last Name:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Middle Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

(Input without dashes)

**Social Security Information-** \* Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at [www.ssa.gov](http://www.ssa.gov) or by calling 1-800-772-1213.

Name: \_\_\_\_\_

### 3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

\_\_\_\_\_

B. Do you hold, or have you ever held a license to practice as a genetic counselor or any other health-related license(s)?    Yes    No

C. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

**Submit a License Verification form to ALL your state(s) of licensure.** License verifications must be received directly from the licensing authority regardless of the status of the license.

### 4. EDUCATION HISTORY

A. List master's/doctoral education, in chronological order.

School Name	City/State or Country	Dates of Attendance: From-To (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)	Degree Awarded
		to		Master's Doctoral
		to		Master's Doctoral
		to		Master's Doctoral
		to		Master's Doctoral

**All applicants must** have an official transcript forwarded directly to office from the educational program. Transcripts may be mailed to the address below or by secure electronic delivery to: [MQA.GeneticCounseling@flhealth.gov](mailto:MQA.GeneticCounseling@flhealth.gov).

**Genetic Counseling**  
4052 Bald Cypress Way, Bin C-08  
Tallahassee, FL 32399-3258

B. Check the appropriate box of the certification body where the certification examination was passed and indicate the specialty.

Certifying Body	Issue Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
American Board of Medical Genetics and Genomics (AMBGG)		
American Board of Genetic Counseling, Inc. (ABGC)		
Canadian Association of Genetic Counsellors (CAGC)		
Canadian Board of Genetic Counseling (CBGC)		
Canadian College of Medical Geneticists (CCMG)		

**All applicants must** have the appropriate certifying body submit verification of passing the certification examination directly to the Department of Health at:

**Genetic Counseling**  
4052 Bald Cypress Way, Bin C-08  
Tallahassee, FL 32399-3258

**This information is exempt from public records disclosure.**

## 5. HEALTH HISTORY

The department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in chapter (ch.) 456, F.S., and the applicable statutory practice acts.

The department supports applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family, or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The department does not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice?      Yes      No
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice?      Yes      No

**If a "Yes" response was provided** to any of the questions in this section, provide the following documents directly to the office:

**A letter from a licensed health care practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

**A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

Name: \_\_\_\_\_

## 6. DISCIPLINE HISTORY

- A. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction?    Yes    No
- B. Have you ever been refused a license to practice, or the renewal thereof in any state?    Yes    No
- C. Have you ever had an application for a professional license, or any application to practice, denied by any state board or governmental agency (state or country)?    Yes    No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y    N
				Y    N
				Y    N
				Y    N

If you responded "Yes" to any of the questions in this section, you must provide the following:

**A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

## 7. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Yes    No

If you responded "Yes," complete the following: (Attach additional sheets if necessary.)

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y    N
				Y    N
				Y    N

If you responded "Yes" in this section, you must provide the following:

**A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

**Final Dispositions** and **Arrest Records** for all offenses. The Clerk of Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of Court.

**Completion of Sentence Documents.** You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

**8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS**

**IMPORTANT NOTICE:** Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain time frames as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction?      Yes      No

**If you responded “No” to the question above, skip to question 2.**

- a. If “Yes” to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation?      Yes      No
- b. If “Yes” to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)?      Yes      No
- c. If “Yes” to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?  
Yes      No
- d. If “Yes” to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if “Yes,” provide supporting documentation)?  
Yes      No
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?      Yes      No

**If you responded “No” to the question above, skip to question 3.**

- a. If “Yes” to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?      Yes      No
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.?  
Yes      No

**If you responded “No” to the question above, skip to question 4.**

- a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?      Yes      No
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?      Yes      No

**If you responded “No” to the question above, skip to question 5.**

- a. Have you been in good standing with a state Medicaid program for the most recent five years?  
Yes      No
- b. Did termination occur at least 20 years before the date of this application?      Yes      No





Complete verifications must be mailed directly from the verifying agency to:

**Genetic Counseling**

4052 Bald Cypress Way, Bin C-08  
Tallahassee, FL 32399-3258



## Genetic Counselor License Verification Request

**Part I: To be completed by applicant** (Florida requires verification of all your current and previously held licenses.)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name original license was issued under: \_\_\_\_\_

License Number: \_\_\_\_\_ State: \_\_\_\_\_

*I hereby authorize release of any information regarding my licensure status to the Florida Department of Health.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY

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### Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

- \* Typed on an official state form or letterhead
- \* Include an official board seal
- \* Signature and title of state board official

The following information must be included in all verifications:

- \* Licensee name
- \* License number
- \* State or jurisdiction of licensure
- \* Licensure status
- \* Is license in good standing?
- \* Date of issuance/expiration
- \* Licensure method (examination, grandfathering, reciprocity/endorsement)
- \* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- \* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.