

North Dakota State Board of Medical Examiners

CITY CENTER PLAZA, 418 E. BROADWAY AVE., SUITE 12, BISMARCK, ND 58501
PHONE (701) 328-6500 FAX (701) 328-6505

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|----------------|
| DATE RECEIVED |
| FEEES RECEIVED |

Application For Genetic Counselor/Medical Genetics License

Please refer to enclosure for specific instructions.

Date _____

1. BIOGRAPHICAL INFORMATION Please answer every question A through L.

- A. Name _____
(First) (Entire Middle Name) (Last)
- B. Business Address _____
(city) (state) (zip)
Business Phone (____) _____
- C. Home Address _____
(city) (state) (zip)
Home Phone (____) _____
- D. E-mail Address _____
- E. Date of Birth ____/____/____
- F. Place of Birth _____
- G. Height _____
- H. Weight _____
- I. Color of Eyes _____
- J. Color of Hair _____
- K. Identifying Marks _____
- L. Social Security # _____

2. INTENDED PLACE OF PRACTICE

- A. Name and address of hospital, clinic, or office where you intend to practice _____

- B. Anticipated starting date _____
- C. Are you applying for a permanent license or a temporary license? _____
(A temporary license may be issued to an applicant who has been accepted to write the certification exam but has not yet done so.)

3. CERTIFICATION INFORMATION

- A. Have you passed the certifying exam administered by the American Board of Genetic Counselors (ABGC) or the American Board of Medical Genetics (ABMG)?

Yes____ No____ Date _____ Certification # _____
(Attach photocopy of certification)

- B. Is your certification by the ABGC or ABMG currently valid? Yes____ No____

4. LICENSURE INFORMATION

- A. Have you ever been licensed or registered as a genetic counselor in another state? _____

If yes, list states and license/registration number(s) _____

9. PERSONAL DATA

All information received in this section will be verified. If any question is answered YES, a full explanation must be furnished on a separate sheet and attached to this form. That explanation shall be considered a part of this application. Applicants should be aware that the Board routinely receives information from other states and from national sources about actions taken against licenses or registration of genetic counselors/medical geneticists.

- | | Yes | No |
|--|--------------------------|--------------------------|
| A. Have you ever failed a genetic counseling examination, or any portion of a genetic counseling examination, for a genetic counselor license or for any other professional license? (If you ever failed a portion of a genetic counseling exam you must answer “yes” even if you later passed the exam.) | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Have you ever had an application for a professional license denied? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Have you ever been investigated by any licensing board, agency, professional association or medical facility in connection with medical competency, practice act violations, unprofessional conduct or unethical conduct? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Has any disciplinary action ever been instituted which could have affected or could now affect your license to practice in any state or foreign country? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence or been placed on probation or reprimanded at a graduate school or postgraduate training program? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict, deny or limit a professional license? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Have you ever had hospital and/or clinic privileges denied, removed or restricted, or limitations imposed on such privileges or resigned hospital and/or clinic privileges to avoid formal action? | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Are you now or have you ever been named as a defendant or respondent in any malpractice proceeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Have you ever been convicted of any crime, felony or misdemeanor? | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Have you ever been arrested for, or charged with, any crime? | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Within the past five years have you had any physical, mental, or emotional condition which impaired or does impair your ability to practice as a genetic counselor safely and competently? | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Do you currently have or within the past five years have you had a dependency on the use of alcohol or drugs which impaired or does impair your ability to practice a genetic counselor competently? | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Within the past five years, have you engaged in the excessive or habitual use of alcohol or drugs or received any treatment for alcoholism or excessive or illegal drug use? | <input type="checkbox"/> | <input type="checkbox"/> |

10. **AGREEMENT TO UPDATE APPLICATION INFORMATION:**

By signing this section of the North Dakota Board of Medical Examiners license application form, I agree that:

If any of the information supplied on this application form changes, or becomes inaccurate or incomplete before I am granted a license to practice genetic counselor in North Dakota, I will immediately provide the corrected information to the North Dakota Board of Medical Examiners.

Failure to provide such corrected information to the Board will constitute the use of a fraudulent, deceitful, dishonest, or immoral practice in connection with the North Dakota licensing requirements and will, therefore, be a violation of Sec. 50-03-01-11, of the North Dakota Administrative Code, which will subject me to disciplinary action or denial of licensure.

SIGNATURE OF APPLICANT

11. **AFFIDAVIT**

I, _____, being first
(Name of Applicant)

duly sworn, depose and say that I am the person referred to in the foregoing application and the supporting documents attached hereto.

I have carefully read the questions in this application and have answered them completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause of denial, suspension or revocation of my license to practice as a physician assistant in the State of North Dakota.

Furthermore, I hereby authorize all hospitals, clinics, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past or present) and all government agencies (local, state, federal or foreign) to release to the North Dakota State Board of Medical Examiners any information which is material to this application or any subsequent registration, certification or licensure.

SIGNATURE OF APPLICANT

Subscribed and sworn before me this _____ day of _____, 20_____

NOTARY PUBLIC

My Commission expires _____, 20_____

