MINNESOTA
BOARD OF MEDICAL PRACTICE

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CERTIFICATION OF GENETIC COUNSELOR EDUCATION

This form is for certification of Accreditation Council for Genetic Counseling (ACGC) accredited genetic counselor education and must be completed and **emailed or mailed by the facility directly to the Minnesota Board of Medical Practice**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name: _____ SS#: _____

Signature: _____ Date: _____

Date of Degree/Cert.(mo/day/yr)_____ Degree/Cert. Received_____

* *

The school completes the following information:

It is hereby certified that: _____
(Name of Applicant)

Matriculated in: _____
(Name of School)

An ACGC accredited program located at:_____
(City/State of School)

And received a diploma conferring: _____ On:_____
(Degree) (Mo/Day/Year

Any disciplinary action? Yes*☐ No☐

Any derogatory information on file? Yes*☐ No☐

President, Secretary Dean, Registrar

School

Seal**

Print Name: _____

Signature:_____

Title: _____

Date: _____

Phone: _____ Fax_____

***Please** attach letter of explanation.
****If there is no seal, attach letter of explanation on letterhead.