MINNESOTA
BOARD OF MEDICAL PRACTICE

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medical.board@state.mn.us | mn.gov/boards/medical-practice

GENETIC COUNSELOR
Verification of Licensure/Registration/Certification

This form is for verification of all genetic counselor and other healthcare professional licenses or registrations from every jurisdiction issuing any type of license, registration or certification including training and temporary permit, even if license is not current. Each Board completing the form must **email or mail directly to the Minnesota Board of Medical Practice**. Any 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: ________________________

* *

The jurisdiction completes the following information:

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

Date of birth: ____
(Month / Day / Year)

Was issued license/registration/certification number: ________________________

By: ____________________________ On: ____________________________
(State) (Month / Day / Year)

Expiration date is: ____
(Month / Day / Year)

Issued on the basis of: ____

Disciplinary action ever initiated, pending, or invoked? Yes* _____ No _____

Ever voluntarily relinquished credential? Yes* ______ No _____

State Seal**

Print name: ________________________

Signature: ________________________

Title: ____________________________

Date: ____________________________

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