



COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF HEALTH PROFESSIONS LICENSURE  
BOARD OF REGISTRATION OF GENETIC COUNSELORS  
250 Washington Street  
BOSTON, MA 02108  
800-414-0168  
617-973-0806

WEBSITE: [www.mass.gov/dph/boards](http://www.mass.gov/dph/boards)

BOARD OF REGISTRATION OF GENETIC COUNSELORS  
APPLICATION FOR PROVISIONAL LICENSURE

INSTRUCTIONS AND CHECKLIST

**CAREFULLY READ THE FOLLOWING INSTRUCTIONS FOR COMPLETING THE LICENSE APPLICATION. COMPLETE APPLICATIONS MUST INCLUDE THE FOLLOWING DOCUMENTS:**

☐ **PLEASE NOTE:** In order to apply for a provisional license, you must have identified a fully licensed Genetic Counselor or licensed physician as supervisor.

☐ Completed application form with

☐ CORI Form

☐ original passport photo (2x2) and

☐ notary signature

☐ Check or money order payable to the Commonwealth of Massachusetts for **\$300.00** Cash or foreign currency is not accepted and the fee is **nonrefundable**.

➤ **NOTE:** When you apply for a full license, you will be required to pay an additional application and license fee of \$300.00

☐ Official transcripts in a signed and sealed envelopes for all undergraduate programs/degrees, accredited (per ABGC or ABMG) master's or PhD genetic counselor programs/degrees and any other post-secondary programs/degrees. **Transcripts must be complete and indicate the degree and date conferred in mm/dd/yyyy format.**

☐ Verification of licensure status, in signed sealed envelopes, from any state or jurisdiction in which you now or have previously held **any** professional license. Verifications may be sent directly to the Board by the state or other jurisdictions.

☐ If you hold or have ever held a professional licence, you must request and submit a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self Query. To request a Self Query, please contact the National Practitioner Data Bank at 1-800-767-6732 or at [www.npdb-hipdb.com](http://www.npdb-hipdb.com). Include the original report with this application; make a copy for your records.

➤ **NOTE:** If you do **NOT** hold and have never held a professional licenses in any other state, you do not need to submit a National Practitioner Data Bank self-query.

- ☐ Name of supervisor with contact information and signature.
- ☐ Application must be submitted on single-sided paper.

**IMPORTANT INFORMATION:**

In order to apply for a license, you must submit verification from ABGC or ABMG that you are registered to take the next certification examination. This must be in hard copy format; email verifications are not acceptable. In the event that you fail the certification examination you must submit hard copy verification from ABGC or ABMG stating that you continue to maintain active candidate status or have registered to retake the examination on the next available administration. Your provisional license shall remain valid until the results of the re-examination are published.

**If you fail to pass a second time, you must cease practicing immediately.**

Pursuant to Board regulation at 270 CMR 3.07 (1), a genetic counselor applicant/ licensee must notify the Board in writing of any of the following events within 30 days of their occurrence, including but not limited to any change of address, any name change, and change in the identity or address of the supervisor of the applicant/licensee.

Pursuant to 270 CMR 3.02 (3), an application is no longer valid if requirements for genetic counselor licensure are not met within one (1) year from the date of Board receipt of this application. All fees are non-refundable and non-transferable.

The address printed on your license is a **PUBLIC RECORD** that is available to the public. Address changes may be done online at the board's website [www.mass.gov/dph/boards](http://www.mass.gov/dph/boards) or you may obtain a form online to submit to the Board's office. Please be advised that address changes can take 4-6 weeks to be processed.

The address of record is where the Board mails your license and any correspondence.

Retain a copy of all information and the completed application for licensure for your records. Employers may require that you provide them with a copy.

Answers to many questions may be found on the Board's website. Statutes and regulations governing genetic counselor licensure may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168.

**APPLICATION FOR PROVISIONAL LICENSE**

BOARD OF REGISTRATION OF GENETIC COUNSELORS • 250 WASHINGTON ST 02108  
PHONE: 800-414-0168 • 617-973-0800 • WEBSITE: [WWW.MASS.GOV/DPH/BOARDS](http://WWW.MASS.GOV/DPH/BOARDS)  
Revised 07-2023



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**BOARD OF REGISTRATION OF GENETIC COUNSELORS**

APPLICATION FOR **PROVISIONAL** LICENSURE  
LICENSE APPLICATION - \$ 300.00 (NONREFUNDABLE)

**ALL QUESTIONS MUST BE ANSWERED**

1. APPLICANT NAME: \_\_\_\_\_  
Last First Middle

MAIDEN/OTHER NAME: \_\_\_\_\_  
(if applicable) Last First Middle

2. ADDRESS OF RECORD: \_\_\_\_\_  
Number Street Apt. Number

City/Town State Zip Code

3. MOST RECENT PREVIOUS ADDRESS: \_\_\_\_\_  
Number Street Apt. Number

City/Town State Zip Code

4. TELEPHONE NUMBER(S) Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_

5. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ EYE COLOR: \_\_\_\_\_  
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)

HEIGHT: \_\_\_\_\_ Feet \_\_\_\_\_ Inches WEIGHT: \_\_\_\_\_ Lbs. MOTHER'S MAIDEN NAME: \_\_\_\_\_

6. SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Pursuant to G.L. c. 30A, s. 13A and G.L. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

**FOR BOARD USE ONLY**

Application Number: \_\_\_\_\_

Receipt Number: \_\_\_\_\_

Provisional License Number:

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## EDUCATION

7. ABGC OR ABMG ACCREDITED DEGREE PROGRAM: \_\_\_\_\_  
Program and Educational Institution

Number Street City State Zip Code  
Degree Awarded: \_\_\_\_\_ Date Degree Awarded: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yyyy)

***Applicant must arrange for an official transcript to be mailed directly to the Board by the degree-awarding institution.***

8. UNDERGRADUATE EDUCATION: \_\_\_\_\_  
Name of Institution

Number Street City State Zip Code  
Degree Awarded: \_\_\_\_\_ Date Degree Awarded: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yyyy)

***Applicant must arrange for an official transcript of undergraduate education to be mailed directly to the Board by the degree-awarding institution.***

9. OTHER EDUCATION: \_\_\_\_\_  
Name of Institution

Number Street City State Zip Code  
Degree Awarded: \_\_\_\_\_ Date Degree Awarded: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yyyy)

***Applicant must arrange for all official transcripts of other post-secondary education to be mailed directly to the Board by the degree-awarding institution.***

10. NAME OF SUPERVISOR: \_\_\_\_\_ LICENSE NUMBER: \_\_\_\_\_

WORK ADDRESS OF SUPERVISOR \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ WORK EMAIL \_\_\_\_\_

**I have reviewed with my supervisee the Guidelines for General Supervision of Provisionally Licensed Genetic Counselors.**

SUPERVISOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

11. GENETIC COUNSELOR CERTIFICATION EXAMINATION

I CERTIFY, UNDER THE PENALTIES FOR PERJURY, THAT:

☐ I TOOK THE **ABGC** CERTIFICATION EXAMINATION ADMINISTERED ON \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

☐ I TOOK THE **ABMG** CERTIFICATION EXAMINATION ADMINISTERED ON \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

☐ I WILL REGISTER FOR AND TAKE THE NEXT AVAILABLE **ABGC** CERTIFICATION EXAMINATION TO BE  
ADMINISTERED ON \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

☐ I WILL REGISTER FOR AND TAKE THE NEXT AVAILABLE **ABMG** CERTIFICATION EXAMINATION TO BE  
ADMINISTERED ON: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

***Applicants must arrange for official verification of certification to be mailed directly to the Board by the ABGC or the ABMG.***

12. APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS**

13. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS HELD IN OTHER JURISDICTIONS:

☐ I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.

| <u>Issuing Jurisdiction</u> | <u>Profession</u> | <u>License/Certification Number</u> |
|-----------------------------|-------------------|-------------------------------------|
| _____                       | _____             | _____                               |
| _____                       | _____             | _____                               |
| _____                       | _____             | _____                               |

***Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board.***

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## QUESTIONS

**IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.**

14. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

15. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

16. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

17. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

18. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$250 or less was imposed.

Yes ☐ No ☐

19. Have you ever been court martialed or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes ☐ No ☐

## RELEASE

### APPLICATION FOR PROVISIONAL LICENSE

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I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and genetic counseling associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Genetic Counselors any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Genetic Counselors to release information contained in this application in association with its processing.

### AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a genetic counselor, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed Genetic Counselor in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure as a Genetic Counselor shall be deemed no longer valid if requirements for provisional licensure as a Genetic Counselor not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration of Genetic Counselors to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

**Attach a  
recent  
2x2 passport  
photo**

NOTARY NAME: \_\_\_\_\_

COMMISSION EXPIRES: \_\_\_\_\_

[Seal]

**INCLUDE A NONREFUNDABLE FEE OF \$300.00 (CHECK OR MONEY ORDER ) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS**

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The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
250 Washington Street, Boston, MA 02108-4619

**Criminal Offender Record Information (CORI) Acknowledgement Form**

To be used by organizations conducting CORI checks for employment or licensing purposes.

The Bureau of Health Professions Licensure is registered under the provisions of M.G.L. c.6, §172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to the Bureau of Health Professions Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Bureau of Health Professions Licensure with written notice of my intent to withdraw consent to a CORI check.

I also understand that the Bureau of Health Professions Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

---

*Signature of CORI Subject*

---

*Date*

**SUBJECT INFORMATION**

Please complete this section using the information of the person whose CORI you are requesting.  
The fields marked with an asterisk (\*) are required fields.

\* First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

\* Last Name: \_\_\_\_\_ Suffix (Jr., Sr., etc.): \_\_\_\_\_

Former Last Name 1: \_\_\_\_\_

Former Last Name 2: \_\_\_\_\_

Former Last Name 3: \_\_\_\_\_

Former Last Name 4: \_\_\_\_\_

\* Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Place of Birth: \_\_\_\_\_

\* Last **SIX** digits of Social Security Number: \_\_\_\_\_ -- \_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Eye Color: \_\_\_\_\_ Race: \_\_\_\_\_

Driver's License or ID Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

Father's Full Name: \_\_\_\_\_

Mother's Full Name: \_\_\_\_\_

**Current Address**

\* Street Address: \_\_\_\_\_

Apt. # or Suite: \_\_\_\_\_ \*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

**SUBJECT VERIFICATION (Complete only if signed by BHPL staff)**

\*The above information was verified by reviewing the following form(s) of government-issued identification:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Verified by:

\_\_\_\_\_  
*Print Name of Verifying BHPL Employee*

\_\_\_\_\_  
*Signature of Verifying BHPL Employee*

\_\_\_\_\_  
*Date*

**Authentication of Signature**

Please note that ALL fields in this section must be completed by the Notary Public. Evidence of identification must be government issued photo ID.

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned notary public,  
\_\_\_\_\_ (name of applicant) personally appeared, proved to me through satisfactory  
evidence of identification, which were \_\_\_\_\_, (Ex: Driver's license, passport, etc.) to  
be the person who signed the preceding document in my presence and who swore or affirmed to me that the contents of  
the document are truthful and accurate to the best of (his) (her) knowledge and belief.

Seal of Notary Public

Notary Public Signature \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

Commission Expires: \_\_\_\_\_