



# HEALTH LICENSING OFFICE

## Genetic Counseling Program

1430 Tandem Ave. NE, Suite 180, Salem, OR 97301-2192  
 Phone: (503) 378-8667 | Web: [www.oregon.gov/oha/ph/hlo](http://www.oregon.gov/oha/ph/hlo)

For Office Use Only		
Applicant #:	License #:	Staff Initials:

### GENETIC COUNSELOR LICENSE APPLICATION

#### Applicant Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
BIRTHDATE:	GENDER: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> NONBINARY / OTHER	
RESIDENTIAL PHYSICAL ADDRESS <b>(REQUIRED)</b> :		
CITY:	STATE:	ZIP:
MAILING ADDRESS (IF DIFFERENT FROM ABOVE):		
CITY:	STATE:	ZIP:
BUSINESS PHONE:	PERSONAL PHONE:	
EMAIL <b>(REQUIRED)</b> :	SOCIAL SECURITY # <b>(REQUIRED)</b> :	

Have you ever been known under any other legal name?  No  Yes  
 If yes, list all previous full (legal) names:

Do you hold or have you previously held licensure, certification or registration with the Health Licensing Office or any other state?  No  Yes - If yes, please list information below (add additional blank page if necessary):

State:	Lic./Cert./Reg. #:	Expiration:
State:	Lic./Cert./Reg. #:	Expiration:

#### Payment Information (complete this section only if submitting payment by mail)

**Required Fees:** (\*The application fee is non-refundable)  
**\*Application Fee = \$150; License Fee = \$50; Total of \$200**

Please check one:  Credit Card (see below)     Check     Money Order     Purchase Order    **DO NOT MAIL CASH**

Type of Credit Card:  Visa     MasterCard     Discover (Cardholder must either be the applicant or be present at the time application is submitted)    **Do not fax or email credit card information (send by way of postal mail)**

Name on card: \_\_\_\_\_

Card number: \_\_\_\_\_ Exp: \_\_\_\_\_ Authorized amount: \$ \_\_\_\_\_

Cardholder signature: \_\_\_\_\_

#### (Do not write in the following section – Official use only)

Method of Payment: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> MO <input type="checkbox"/> PO AMOUNT: _____ INITIALS: _____ <input type="checkbox"/> APPROVAL CODE/CK#: _____	Method of Payment: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> MO <input type="checkbox"/> PO AMOUNT: _____ INITIALS: _____ <input type="checkbox"/> APPROVAL CODE/CK#: _____	Method of Payment: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> MO <input type="checkbox"/> PO AMOUNT: _____ INITIALS: _____ <input type="checkbox"/> APPROVAL CODE/CK#: _____
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## Individual Records Questions

Please accurately answer all of the questions below. The Health Licensing Office may review your information through the Law Enforcement Data System, other governmental agencies, and private vendors to confirm the accuracy of the information. Any misrepresentation or failure to disclose information may result in disciplinary action.

1. Are you now, or have you ever been, the subject of any active or inactive disciplinary action or voluntary resignation of a professional license, certificate, registration or permit imposed by a licensing or regulatory authority in this or any other state? Disciplinary action includes, but is not limited to, probation, suspension, civil penalty, or any other sanction limiting, in any way, a license, certificate, registration or permit.

Yes  No If yes, please attach an additional page of paper providing an explanation of the circumstances.

2. Have you ever been convicted of a misdemeanor or felony?  Yes  No  
If yes, please list **all** convictions, including the charges as stated in the court documents and year convicted  
**(attach additional pages if necessary).**

**Year  
Convicted**

3. As of today, are you on probation or parole?  Yes  No If yes, you **must** provide a letter of release from your probation or parole officer authorizing you to obtain an authorization to practice. If you are on bench probation, or probation with the court, you must provide documentation of your conditions of the probation.

## Mandatory Social Security Number Disclosure and Use

You are required to provide your Social Security number (SSN) to the Health Licensing Office (HLO) as part of your application for initial or renewed occupational or professional license, certification, or registration issued by HLO pursuant to ORS 25.785, ORS 305.385, 42 USC § 666(a)(13) and 42 USC §405(c)(2)(C)(i). Failure to provide your SSN will be a basis to refuse to issue or renew the license, certification, or registration you seek. HLO is authorized by law to use your SSN for child support enforcement and tax administration purposes only. HLO will only use your SSN for these purposes unless you authorize other uses of your SSN as discussed below. Your SSN will remain on file with HLO. If you have never been assigned a SSN please refer to the section below titled Request for Exemption from Social Security Number Disclosure and Attestation.

## Voluntary Social Security Number Disclosure and Use

HLO is authorized to conduct criminal background checks pursuant to ORS 181A.195, 676.608, and 676.612. HLO requests that you voluntarily provide your SSN for this purpose. Pursuant to 50 USC § 3931 HLO must determine the military status (or lack thereof) of a respondent before issuing a default final order. HLO requests that you voluntarily provide your SSN for this purpose. Failure to provide your SSN for these purposes will not be used to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your SSN by HLO for these purposes, it may be used only for these purposes.

4. I voluntarily consent to disclose my SSN to HLO for criminal background checks and military verification.  Yes  No

**Applicant Signature:**

**Date:**

**Do not answer this question or sign/date in this section if your license, certification or registration is issued by: The Board of Certified Advanced Estheticians, the Board of Cosmetology, the Board of Electrologists and Body Art Practitioners or the Environmental Health Registration Board.**

For any HLO license, certification, or registration that reports to the National Practitioner Data Bank (NPDB), if any disciplinary action is taken against you, HLO requests that you voluntarily provide your SSN so that HLO may report it to the NPDB under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986; Section 1921 of the Social Security Act; Section 1128E of the Social Security Act; and their implementing regulations found at 45 CFR Part 60. Failure to provide your SSN for this purpose will not be used to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your SSN by HLO for this purpose, it may be used only for this purpose.

5. I voluntarily consent to disclose my SSN to HLO to report to the NPBD.  Yes  No

**Applicant Signature:**

**Date:**

## Request for Exemption from Social Security Number Disclosure and Attestation

If you do not have a Social Security number (SSN) you may request an exemption from the SSN requirement. In order to receive the exemption, you must attest and certify that you have never been assigned a SSN and if you are ever assigned an SSN you will report it to HLO within 30 days.

By my signature below, I attest and certify that I have never been assigned a SSN and agree that if a SSN is assigned to me, I will report it to HLO within 30 days. I understand that providing false information on this application is grounds for denial, suspension, or revocation of my license, certification or registration.

**Applicant Signature:**

**Date:**

**Affirmative Action – Voluntary Question**

The State of Oregon has an Affirmative Action Policy. If you choose to provide the optional information below, it will help us evaluate the effectiveness of our affirmative action programs. This information will also be used in the aggregate (i.e. as a whole, not individually) for research and statistical purposes. It will not be tied specifically or directly to your licensing information.

**Which of the following describes your racial or ethnic identity? Please check all that apply.**

**American Indian and Alaska Native**

- American Indian
- Alaska Native
- Canadian Inuit / Metis / First Nation
- Indigenous Mexican / Central American / South America

**Asian**

- Asian Indian
- Cambodian
- Chinese
- Communities of Myanmar
- Filipino / Filipina
- Hmong
- Japanese
- Korean
- Laotian
- South Asian
- Vietnamese
- Other Asian

**Black and African American**

- African American
- Afro-Caribbean
- Ethiopian
- Somali
- Other African (Black)
- Other Black

**Hispanic and Latino/Latina/Latinx**

- Central American
- Mexican
- South American
- Other Hispanic or Latino/Latina/Latinx

**Middle Eastern / North African**

- Middle Eastern
- North African

**Native Hawaiian and Pacific Islander**

- Chamoru/Chamorro
- Guamanian
- Marshallese / Micronesian / Palauan / Tongan
- Communities of the Micronesian Region
- Native Hawaiian
- Samoan
- Other Pacific Islander

**White**

- Eastern European
- Slavic
- Western European
- Other White

**Other Categories**

- Other: \_\_\_\_\_
- Unknown
- Decline to answer

If you checked more than one race or ethnicity above, is there **one** you think of as your primary racial or ethnic identity?

- Yes, please list: \_\_\_\_\_
- I do not have just one primary racial or ethnic identity
- No, I identify as Bi-racial or Multi-racial
- Not applicable, I only checked one category above
- Unknown
- Decline to answer

**APPLICATION REQUIREMENTS**

**PLEASE NOTE:** The applicant is responsible for payment of fees assessed by the issuing organization(s) when obtaining required official documentation.

**Applicant must:**

_____	Meet the requirements of Oregon Administrative Rule, <a href="#">Chapter 331, Division 30</a> .
_____	Submit this completed application accompanied by payment of required fees: *Application fee = <b>\$150</b> ; and License fee = <b>\$50</b> ; for a total of <b>\$200</b> (see payment section on first page). <b>DO NOT SEND CASH THROUGH THE MAIL.</b> <b>*THE APPLICATION FEE IS NON-REFUNDABLE.</b>
_____	Submit <b>two</b> forms of original identification issued by a government agency. Acceptable identification options can be found under Chapter 331, Division 30 of Oregon Administrative Rule. <b>ID requirements are as follows:</b> <ul style="list-style-type: none"> <li>• The two forms of ID must be issued by a government agency.</li> <li>• Both the ID's must include the applicant's current legal name.</li> <li>• At least one form of ID provided must be photographic.</li> <li>• We do not accept student ID cards, Costco cards, debit cards, etc. If you have a question about whether a particular ID type is acceptable, please call (503) 378-8667, to verify.</li> <li>• If submitting photocopies of your ID by mail, legible (clear) front and back copies must be submitted. Submit the copies on a full-sized piece(s) of copy paper, do not cut the ID images out.</li> </ul> If you do not meet all of ID requirements above, you run the risk of your application process being delayed.
_____	Submit proof of being at least 18 years of age and provide official documentation confirming date of birth, such as a copy of the birth certificate, driver's license, passport or school/military/governmental record with age documented (if not already provided on photographic identification required above).
_____	Arrange for official documentation to be sent directly from the American Board of Genetic Counseling (ABGC) or the American Board of Medical Genetics and Genomics (ABMGG) to the Health Licensing Office showing proof of an active credential specific to genetic counseling. Proof must be issued or mailed directly to the Health Licensing Office from the ABGC or the ABMGG.

**Certification of Information Provided**

I have examined this application and supporting documentation and certify by my signature below that it is true, correct and complete. I understand that making a false statement on this application will be cause for denial, suspension, or revocation of my license, certification or registration. I have enclosed the required fees and documentation.

**Applicant Signature:**

**Date:**