NEVADA STATE BOARD OF MEDICAL EXAMINERS

FEES FOR GENETIC COUNSELOR LICENSURE

Applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Applications must be received on single-sided, white bond paper, 8 ½" x 11" in size. Your application is a public document.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

Fees applicable if licensed between January 1, 2026 – June 30, 2026:

Application Fee	Registration Fee	Criminal Background Investigation Fee		
$300	$400	$75	=	$775

Fees applicable if licensed between July 1, 2026 – June 30, 2027:

Application Fee	Registration Fee	Criminal Background Investigation Fee		
$300	$200	$75	=	$575

The Application fee and Criminal Background Investigation fee will not be refunded. You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two and a half percent (2.5%) service fee will be assessed for payment by credit card.

The Board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances** warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.

** You **may** be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a 13, 20, 21, 22, 23, and/or 24.

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the National Practitioner Data Bank and Federation of State Medical Boards of the United States, Inc. among other entities.

Nevada Revised Statutes – Genetic Counselor Licensure

SB189, from the 2025 Legislative Session, Section 7:

To be eligible for licensing by the Board as a genetic counselor, an applicant must:

1. Be a natural person of good moral character;
2. Submit a completed application as required by the Board by the date established by the Board;
3. Submit the fee prescribed by the Board pursuant to NRS 630.268;
4. Have received a master's degree or higher in genetic counseling from a program in genetic counseling that is:
   (a) Accredited by the Accreditation Council for Genetic Counseling, or its successor organization; or
   (b) Located in a foreign country and has educational standards that are at least as stringent as those established by the Accreditation Council for Genetic Counseling, or its successor organization, as determined by the Board;
5. Pass the examination administered by the American Board of Genetic Counseling, or its successor organization, or the examination in clinical genetics and genomics administered by the American Board of Medical Genetics and Genomics, or its successor organization; and
6. Hold a valid certification issued by the American Board of Genetic Counseling, or its successor organization.

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS Chapter 630 as amended by Section 12 of SB189 from the 2025 Legislative Session:

1. The following acts constitute grounds for initiating disciplinary action against a genetic counselor or denying licensure as a genetic counselor:

(a) Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice genetic counseling by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.

(b) Disobeying any order of the Board or an investigative committee of the Board.

(c) Conviction of:

(1) A crime relating to the practice of genetic counseling;

(2) A violation of any of the provisions of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive; or

(3) Any offense involving moral turpitude.

(d) Being adjudicated incompetent or incapacitated.

(e) Advertising the practice of genetic counseling in a false, deceptive or misleading manner.

(f) Advertising, practicing or attempting to practice genetic counseling under a name other than one's own.

(g) Practicing or assisting in the practice of genetic counseling while under the influence of alcohol, any controlled substance or any other substance which impairs the mental capacity of the genetic counselor.

(h) Violating the Code of Ethics adopted by reference pursuant to section 6 of this act.

(i) Lack of ability to safely and skillfully practice genetic counseling due to a lack of knowledge or training or the inability to apply professional principles and skills.

(j) Violating or attempting to violate, or assisting or abetting the violation of, or conspiring to violate any provision of this chapter or the regulations adopted pursuant thereto.

(k) Any disciplinary action, including, without limitation, the revocation, suspension, modification or limitation of a license to practice genetic counseling, taken by another state, the Federal Government, a foreign country or any other jurisdiction or the surrender of the license or discontinuing the practice of genetic counseling while under investigation by any licensing authority, a medical facility, a branch of the Armed Forces of the United States, an insurance company, an agency of the Federal Government or an employer.

(l) Failure to be found competent to practice genetic counseling as a result of an examination to determine competency pursuant to NRS 630.318.

(m) Performing or supervising the performance of a pelvic examination in violation of NRS 629.085.

(n) Operation of a medical facility at any time during which:

(1) The license of the facility is suspended or revoked; or

(2) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.

This paragraph applies to an owner or other principal responsible for the operation of the facility.

(o) Any other grounds specified by regulation of the Board.

2. A genetic counselor shall notify the Board not later than 48 hours after the certification of the genetic counselor by the American Board of Genetic Counseling, or its successor organization, lapses or is revoked. Upon receipt of such notification, the Board shall immediately revoke the license of the genetic counselor.

Genetic Counselor – Application Checklist

____	a.	APPLICATION: • Properly completed, signed and notarized application, including Applicant Responsibility statement; • Recent passport quality photograph (at least 2"x 2"); • Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 20, 21, 22, 23, 24, and 25; • Release form - signed and notarized (Form A);
____	b.	FEES: • Proper application, registration, AND criminal background investigation fees – cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form or online via the Applicant Portal. Note: Application and criminal background investigation fees are non-refundable;
____	c.	IDENTITY: • **U.S. born citizens** – Photocopy of U.S. Birth Certificate or current (unexpired) U.S. passport with ***notarized*** Certificate of Identification • Proof of affiliation with the Armed Forces of the United States (DD214, Orders, Military ID., etc.) *if applicable*; • **Foreign-born citizens** – Photocopy of current (unexpired) U.S. passport or Certificate of Naturalization with ***notarized*** Certificate of Identification • **Non U.S. citizens –** Copy of both sides of Alien Registration card, Employment Authorization card, or Visa and copy of foreign passport;
____	d.	SELF-QUERY VERIFICATION: • Self-query response from the National Practitioner Data Bank (NPDB); The NPDB will send the report directly to you and you will forward the final report to the Board office; The request form for the National Practitioner Data Bank (NPDB) is available at http://www.npdb.hrsa.gov. Click on 'Self-Query' for Healthcare Professionals on the right side of the page and follow the instructions provided. If you require additional information, please call the NPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB, forward a copy of this report to the Board office.
____	e.	SUPPLEMENTARY FORM: • FORM B: ONLY if you have answered affirmatively to either of the two malpractice questions on the application. List all carriers held within the past 10 years. Also include; o Copy of the legal Complaint o Copy of the Settlement and/or filed Dismissal
____	f.	EDUCATION: • Copy of transcripts or diplomas for degrees other than Genetic Counselor degree – an Associates, Bachelors or Masters Degree that you would like added to your educational profile on the Board's website **(optional)**;
____	g.	FINGERPRINTING: • Once the application and criminal background investigation fee have been received, fingerprint instructions will be sent to you. Applicants within the State of Nevada may complete a physical fingerprint card or may obtain electronic fingerprints (i.e., LiveScan). Applicants outside of Nevada must complete a physical fingerprint card. You will take the fingerprint instructions to a fingerprinting service or Law Enforcement agency so they may use the correct card (if applicable) and enter the necessary information. Completed card or Fingerprint Request Form must be returned to the Board. Fingerprints obtained prior to application submission must be accompanied by a signed Civil Applicant Waiver, dated on or before the fingerprint date. Note: Receipt of the Criminal history background results will not delay licensure.

Revised 11/21/2025

GENETIC COUNSELOR
APPLICATION CHECKLIST

DIRECT SOURCE VERIFICATIONS
TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN
BY THE VERIFYING INSTITUTION TO BOARD OFFICE

Verifying agencies may charge a fee. ***Do not provide pre-stamped or pre-addressed envelopes for direct source verifications.***

_____	a.	GENETIC COUNSELOR SCHOOL: ☐ Verification of completion of Genetic Counselor Education (Form 1) to be completed by your Genetic Counselor program; ☐ Official transcripts from your Genetic Counselor program;
_____	b.	EXAMINATION: • Current certification by the American Board of Genetic Counseling (ABGC) (Form 2)
_____	d.	MALPRACTICE INSURANCE CARRIER VERIFICATIONS: • Malpractice insurance carrier verification (Form 4) to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report for any and all malpractice cases that occurred within the past 10 years with a liability, settlement or claim paid on your behalf (see Disclaimer below).

Disclaimer: Per Nevada Revised Statute (NRS) 630.173(2), the Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

APPLICATION GUIDE

Identity - Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name i.e. U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or other legal documentation reflecting name change.

Malpractice - If you have ever been named in a legal action involving professional liability (malpractice), whether or not you have ever had a professional liability, settlement, claim paid on your behalf, or paid such a claim yourself, provide signed and dated explanations for all malpractice cases throughout your career. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed, which includes copies of Complaints, Settlements and/or Dismissals. If you have a pending case or cases, request a letter from your attorney to be sent directly to the Board describing the current status of the case(s). In summary:

- Provide descriptive explanations for any and all malpractice cases (who, what, where, when and why);
- Complete Form B listing all malpractice insurance carriers;
- Provide copies of legal documentation for cases that occurred within the past 10 years:
    - Complaint
    - Settlement
    - and/or Dismissal.
- Request malpractice carrier verifications (Form 4) from all malpractice insurance carriers within the past 10 years if you have been named in a malpractice case where there was a liability, settlement or claim paid on your behalf;
- For any pending case(s), request a status letter to be sent directly to the Board from your attorney.

Investigation - If you have ever been notified that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violations of a statute, rule or regulation governing your practice as a physician assistant, you should answer affirmatively to question #24 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation unless otherwise instructed.

Arrest - If you have **ever** been arrested, read question #13 carefully. You will be expected to provide a signed and dated explanation addressed to the Nevada State Board of Medical Examiners for any arrest(s) no matter how long ago it may have occurred, whether it was expunged or not. You may be asked to provide a copy of the arrest report, proof of completion of probation and/or time served, community service, fines paid and any other documentation applicable to the incident(s).

Release for Communication with a Person other than the Applicant: If you wish to authorize the Board to communicate about the status of your application for licensure with someone other than yourself, provide a brief signed written release of authorization indicating the specific name of the person thus providing the Board with authority to tender information related to your application status.

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information that is more than 10 years old regarding malpractice, investigations by another licensing board, complaints or disciplinary actions from a hospital, clinic or medical facility if the Board receives the information from the applicant or any other source from which the Board is verifying the information provided by the applicant.

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during your training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

○ ○ ○ ○ ○

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name _____

Sign your name _____

Date _____

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

Nevada Department of
Public Safety

As an applicant who is subject pursuant to NRS 630.167, and who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below. All notices must be provided to you in writing. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28 Code of Federal Regulations (CFR), 50.12, among other authorities.

1.You must be notified by Nevada State Board of Medical Examiners that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.

2.Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

3.Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

4.Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

5. If you have a criminal history record, you should be afforded a reasonable amount to time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the FBI criminal history record. The procedures for obtaining a change, correction, or update of your FBI criminal history record as set forth at, 28 CFR 16.34 provides for the proper procedure to do so.

Applicant's Initials: _____ Date:_____

6. If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record,

you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https://www.fbi.gov/services/cjis/identity-history-summary-checks and https://www.edo.cjis.gov .

7. If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI by submitting a request via https://www.edo.cjis.gov . The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

8. You have the right to expect that officials receiving the results of the fingerprint-based criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal or state statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

9. I hereby authorize Nevada State Board of Medical Examiners to submit a set of my fingerprints to the Nevada Department Public Safety, Records Bureau for the purpose of accessing and reviewing State of Nevada and FBI criminal history records that may pertain to me.

10. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original. In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the above.

Applicant's Name: _____
PLEASE PRINT Last Name First Name Middle

Applicant's Signature: _____

Date: _____

Agency Account #: 881183

Agency Representative: _____
PLEASE PRINT Linn Kory

Agency Representative Signature: *K. Linn, Chief of Licensing*

Date: 1.30.23

GENETIC COUNSELOR
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559

Date Received by Board

License No._____
File No._____

For Board Use Only

Identity:

1. Present Legal Name _____
Last First Middle Maiden

List any other name ever used _____

Address:
The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.
The **Mailing Address** that you choose will not be made public, unless it is also listed as your public address. It can be one and the same.

2. Public Address _____
Street City County State Zip

☐ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
Street City County State Zip

4. Telephone Numbers (_____)_____ (_____)_____ (_____)_____ (_____)_____
Office Fax Home Cellular (Optional)

Email address_____

5. Date of Birth _____Place of Birth _____Gender____F____M
(Month / Day / Year) (City / State / Country)

6. Citizenship: U.S. Citizen _____ Alien Registration #_____ Employment Authorization # _____ Visa_____

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number _____ Height _____ Weight _____ Color of Eyes _____ Color of Hair _____

NRS 630.197(1)(a) An applicant for the issuance of a license to practice as a genetic counselor shall include the social security number of the applicant in the application submitted to the Board.
NAC 290(2)(c) An applicant must submit to the Board such further evidence and other documents or proof of qualifications as required by the Board.

Questions:

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice as a genetic counselor" is to be construed to include all of the following:
1. The cognitive capacity to engage in the practice of genetic counseling, exercise reasoned clinical judgments, and to learn and keep abreast of genetics developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber=s direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice as a genetic counselor with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice as a genetic counselor, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No _____N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice as a genetic counselor with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No _____N/A

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?
(If "Yes," attach explanation on separate sheet.) _____Yes _____No

Malpractice Questions:

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?

_____Yes _____No

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?

_____Yes _____No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

☐ Open ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit or court filing:

Insurance carrier at time:

What is/was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Arrest Question:

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. _____Yes _____No

(If "Yes," attach explanation on separate sheet.)

Nevada License History:

14. Have you previously applied for an allied health license in Nevada? _____Yes _____No

(If "Yes," attach explanation on separate sheet.)

Genetic Counselor Education:

All information must begin on the application, if more space is needed, please attach separate sheet.

15. List all schools attended, type of degree received and dates of attendance. **Also list your Genetic Counselor school information.**

Name	City/State	Type of Degree Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr,)

16. Genetic Counselor Degree granted by:

Genetic Counselor School	City / State	Exact Date of Issuance (Month/Day/Year)

Activities:

17. Account for, in chronological order, all activities for the five (5) years preceding your application submission date. Activities include working as a Genetic Counselor and also non-medical activities (seeking employment, moving, job search, applying for a license, vacation etc.) **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.**

Activities	City / State (and Country if other than U.S.)	From (Mo./Yr.) To (Mo./Yr.)	Percent Clinical (%)

State licenses:

18. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as a Genetic Counselor in any state, territory or country:

State/Territory	License #	Date of Issuance (Mo./Yr.)	Status

Examinations:

19. Are you currently certified by the American Board of Genetic Counseling (ABGC)? _____Yes _____No

If "Yes:" certification number _____ certification expires _____

If "No:" date scheduled to sit for the examination _____ *

Disciplinary Questions:

20. Have you ever been denied a license or certificate to practice as a genetic counselor, or in any other healing art, or permission to take an examination to practice as a genetic counselor or in any other healing art(s) in any state, country or U.S. territory? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

21. Have you ever had a genetic counselor license or certificate, or license or certificate to practice in any other healing art, revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

22. Have you ever voluntarily surrendered a license or certificate to practice as a genetic counselor, or in any other healing art, in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

23. Have you ever failed the ABCG or ABMGG examination, or any state or other jurisdiction examination for certification as a genetic counselor? (If "Yes," attach explanation on separate sheet.) _____Yes _____No

24. Have you ever been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; **or** e) convicted of any violation of a statute, rule or regulation governing your practice as a genetic counselor by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? _____Yes _____No
(If "Yes," attach explanation on separate sheet.)

Attestations/Affirmations:

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. _____Yes _____No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for genetic counselors who practice in the State of Nevada or via telehealth and whose physical presence exists outside the state of Nevada or the United States

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: _____

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? _____Yes _____No
If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

2-If yes, which branch of service did you serve?
- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corp
- ☐ Coast Guard
- ☐ Space Force

3-Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

4&5-Dates of service in the Military:
4-From: _____/ _____/ _____ **5-To:** _____/ _____/ _____
DD MM YYYY DD MM YYYY

6-Are you still serving? _____Yes _____ No

7-Have you ever served on active duty in the Armed Forces of the United States? _____Yes _____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____Yes _____No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged, your answer should be "Yes.") _____Yes _____No

---

APPLICANT PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

_____ _____
Signature of applicant **Date**

APPLICATION AFFIRMATION

I,

_____,

(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

_____ _____

Signature of applicant **Date**

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____

City State

_____

Signature of Notary

END OF APPLICATION

FORM A

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the State of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature of Notary

A photocopy of this form will serve as an original (Board use only).

Please return completed form to:

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers held **within the past 10 years.**

Name of Insured: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

Insurance Company: ______________________________
Address: ______________________________
____
Phone Number: ______________________________
Fax Number: ______________________________
Policy Number: ______________________________
Dates: ______________________________

(If more space is needed, please copy this page or attach a separate sheet.)

Applicant: *Each school where physician assistant education was received must complete this form. If more than one school, photocopies of this blank form may be made and used. Transcripts must also be submitted by the school(s).*

FORM 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
GENETIC COUNSELOR EDUCATION VERIFICATION

This certifies that _____
Printed Name of Applicant — Date of Birth

was enrolled in _____
Name of Genetic Counselor School — (Location – City / State / Country)

The following information to be completed by program only!

The undersigned further certifies that the records of this institution show that the applicant attended this institution

from _____ to _____
(month / year) (month / year)

The applicant was granted:

☐ Master's Degree in Genetic Counseling

☐ Other Advanced Degree in Genetic Counseling (Please attach explanation)

The degree was granted: _____
(month / day / year)

Signed and the institutional seal affixed this

_____ day of _____ , 2 _____

Affix Seal Here

By: _____
Printed name of President, Registrar or Dean

Title _____
Title of President, Registrar or Dean

Signature _____
Signature of President, Registrar or Dean **

Telephone: _____
Fax: _____
Email: _____

** Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.

Completed form is to be mailed by the verifying institution directly to:

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
***or* email to nsbme@medboard.nv.gov**

Genetic Counselor School : *If you have questions, you may contact the Board at (775) 688-2559. The Board requires that this verification form be received by mail or email and NOT by facsimile.*

Applicant: *This form is to be mailed to the ABGC for completion. You may prefer to contact the ABGC to request that an electronic verification to be sent to the Nevada State Board of Medical Examiners.*

FORM 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS
ABGC CERTIFICATION

American Board of Genetic Counseling
18000 W. 105th Street
Olathe, KS 66061
(913) 895-4789
www.abgc.net

Part 1 – to be completed by applicant

I, _____ am in the process
(Name of Applicant)
of applying for a genetic counselor license in the state of Nevada and hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners.

_____
(Signature of Applicant)

- -

Part 2 – to be completed by ABGC and returned directly to the Nevada State Board of Medical Examiners

I, the undersigned, certify that _____
(Name Of Applicant)
was granted initial certification by the American Board of Genetic Counseling

on: Date Issued _____

Certificate Number _____.

The above certificate is: _____ current, in good standing _____ not current.

Expiration date of current certification: _____.

AFFIX BOARD SEAL HERE

Signature of certifying individual: _____
Print name: _____
Title: _____
Date: _____
Email: _____

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
(775) 688 – 2559
nsbme@medboard.nv.gov

Applicant: *If you answered affirmatively to questions #12 and #12a on the Application for Licensure, complete both the top portion and release area of this form; have this form notarized, and submit this form to all malpractice carriers verifying coverage* ***within the past 10 years****. Copies of this form may be used if you have more than one malpractice carrier.*

FORM 4

MALPRACTICE CLAIM VERIFICATION REQUEST

Insurance Carrier Information:

Name of Insured Genetic Counselor**:** _____

Name of Insurance Company: _____

Address: _____

_____

_____

Phone: _____ Fax: _____

To be completed by verifying agency only

Policy Number: _____

Policy Period From: _____ To: _____

**Please provide a loss history report with this verification.

Claims Experience:

Has this Genetic Counselor had a settlement paid on his/her behalf? _____Yes _____No

If "yes", please provide the following information:

Occurrence Date	*Status*	*Date Closed*	*Indemnity Amount*
_____	_____	_____	_____

*Description of Claim:*_____

_____

Insurance Carrier Agent:

_____
Print Name and Title

_____
Signature of Agent

_____
Telephone

_____
Email address

Please mail completed form to:

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the State of Nevada.

_____
Genetic Counselor (applicant) signature and date

Subscribed and sworn to before me this _____ day of

_____, 2_____,

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

_____
Signature and Seal of Notary Public

Malpractice Insurance Carrier: *If you have questions, you may contact the Nevada Board at (775) 688-2559.*

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
or fax to:
775-688-2321

***Please type or print legibly*.**

Method of Payment: MasterCard / Visa / American Express / Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Name of Applicant (if applying for licensure): _____

Credit Card Number: _____

Expiration Date: _____ / _____ *(MM) (YYYY)*

Credit Card Verification Code (CVC): _____ *(Three or four digit code found on the front or back of the card)*

For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a

One-time payment in the amount of $_____.

Printed Name: _____

Authorized Signature: _____Date:_____

Email Address for receipt: _____

***Disclosure*: By continuing, you will be charged a non-refundable card payment-processing fee of 2.5% for debit and credit cards by our payment processor. If you do not wish to pay the fee, you can select another payment option.**