

THIS IS NOT THE APPLICATION FOR A TEMPORARY LICENSE TO PRACTICE GENETIC COUNSELING
INSTRUCTIONS FOR COMPLETING AN APPLICATION TO PRACTICE GENETIC COUNSELING IN VIRGINIA

(This form has been designed to be used as a checklist when preparing to submit your application.)

APPLICATION FEES ARE NONREFUNDABLE

BEFORE YOU PROCEED, READ THE FOLLOWING POINTS CAREFULLY!

You should familiarize yourself with the qualifications required for a license by reviewing the laws and regulations governing the practice of genetic counseling in Virginia. They can be found at:

http://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm

The Board works as efficiently as possible to process applications. The time from filing an application with the Board until the issuance of a license is dependent upon entities over which the Board has no control. It is the applicant's responsibility to ensure that outside entities send the necessary documentation to the Board. You should not expect the process to take less than 2-3 months, so plan accordingly if you are pursuing a practice position in Virginia.

The Board provides an electronic checklist for your convenience in tracking your application. You should allow approximately 15 days for your application checklist to be first updated on the Board's website. Supporting documentation will be added to your checklist as it is received. Processing of documents may take up to 10 business days after they are received. If you find your checklist does not exist or does not indicate necessary documents have been received, e-mail the Board at medbd@dhp.virginia.gov with "Genetic Counselor Application Question" in the subject line. E-mails will be answered within 2 business days.

Your application checklist may be viewed by logging into your application and clicking on the "View Checklist" link located in the Pending Licenses section. This link will not be visible for applicants who have not yet paid the application fee. If you have submitted your application and required fee online, but no longer see your checklist listed in the Pending Licensing section, your license may have been issued by the Board. Please visit <https://www.license.dhp.virginia.gov/license/> and use your current User ID and Password to log in and view your newly issued license. If you need technical assistance with your checklist, contact the agency's helpdesk at 804-367-4444. The helpdesk cannot provide assistance regarding information about your documents.

Supporting documentation sent to the Board when there is no application on file will be purged after six months.

NB: Virginia law considers material misrepresentation of fact in an application for licensure to be a Class 1 misdemeanor. Misrepresentation may be by commission or omission. Be sure of your facts and provide full responses to the Board's questions.

PROCEEDING TO THE APPLICATION SIGNIFIES THAT YOU HAVE READ AND ACCEPT THE FOREGOING PRINCIPLES REGARDING THE BOARD'S PROCESSES.

You have selected to begin an initial application to practice as a Genetic Counselor. If this license type is incorrect, please contact us at (804) 367-4444 for assistance.

Application requirements:

1. Complete the online application: <https://www.license.dhp.virginia.gov/apply/> which includes paying the nonrefundable application fee of \$130.00. Application fees may only be paid using Visa, MasterCard or Discover.

2. An applicant for a license to practice as a genetic counselor shall provide original source documentation (not a copy) of the following:

Transcripts documenting completion of a Master's Degree from a genetic counseling training program that is accredited by the Accreditation Council of Genetic Counseling.

Transcripts must be official and bear the school seal. Transcripts will only be accepted if they come directly from the school to the Board or if sent to the Board by the applicant in the same unopened envelope in which they were received.

3 A notarized copy of a current, valid certificate issued by the ABGC or ABMG to practice genetic counseling.

4 *Verification of Practice:* A completed Form B Activity Questionnaire or a letter of recommendation must be received from all locations of service, professional employment, observerships, professional research positions or professional volunteer service listed for the past 5 years. **The Board must receive a completed form B from each location where you provided services as a genetic counselor for the past 5 years. Form B Activity Questionnaires may be completed by another genetic counselor or a physician who is familiar with your practice.**

Form B's sent to the Virginia Board of Medicine by the applicant will not be accepted.

If you are a new graduate with no professional practice experience you will have no Form B's to provide.

5. *License Verification:* Verification of genetic counselor licenses or certificates to practice from all jurisdictions within the United States, its territories and possessions or Canada in which you have been issued a license, certification or registration must be received by the Board and must verify whether or not disciplinary action has been taken or is pending in that jurisdiction. **Please contact the applicable jurisdiction where you have been issued a license to practice genetic counseling to inquire about having documentation forwarded to the Virginia Board of Medicine.** Verification must come from the jurisdiction and may be sent by email to medbd@dhp.virginia.gov, faxed to (804) 527-4426 or mailed.

If you do not hold licensure in any other state or jurisdiction, you will have no license verification to provide.

Please note:

- ▶ Applications not completed within 12 months may be purged without notice from the Board.
- ▶ Additional information not already listed may be requested at any time during the process.
- ▶ Application fees are non-refundable.
- ▶ The Board's mailing address is **The Virginia Board of Medicine
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233**
- ▶ Email inquiries are normally responded to within 2 business days. Send your email inquiries to medbd@dhp.virginia.gov.
- ▶ Submission of an application does not guarantee a license. A review of your application could result in the finding that you may not be eligible pursuant to Virginia laws and regulations.

**VIRGINIA BOARD OF MEDICINE
CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM**

The Law

In 1997, the General Assembly of Virginia passed a law (§ 54.1-2912.1) to ensure the continued competency of practitioners licensed by the Board of Medicine. It directed the Board to include in its regulations continuing education, testing, and/or any other requirement which would address the following: a) the need to promote ethical practice, b) an appropriate standard of care, c) patient safety, d) application of new medical technology, e) appropriate communication with patients and f) knowledge of the changing health care system.

Rationale for the Regulation

The Virginia Board of Medicine recognizes that the professional responsibility of practitioners requires *continuous learning* throughout their careers, appropriate to the individual practitioner's needs. The Board also recognizes that practitioners are responsible for choosing their own continuing education and for evaluating their own learning achievement. *The regulation of the Board is designed to encourage and foster self-directed practitioner participation in education.*

What is "Continuing Learning"? - Continuing learning includes processes whereby practitioners engage in activities with the conscious intention of bringing about changes in attitudes, skills, or knowledge, for the purpose of identifying or solving ethical, professional, community or other problems which affect the health of the public.

Content of the Regulation

A. In order to renew an active license biennially, a licensee shall complete the Continued Competency Activity and Assessment Form that is provided by the board indicating completion of at least 50 contact hours of continuing learning activities as follows:

1. A minimum of 30 of the 50 hours shall be in Category 1 activities approved by the ABGC, the ABMG or the NSGC and may include in-service training, self-study courses, continuing education courses, or professional workshops.
2. No more than 20 of the 50 hours may be Category 2 activities or professional activity credits, which may include consultation with another counselor or a physician, independent reading or research, authorship, clinical supervision, volunteer leadership in the profession, preparation for a presentation or other such experiences that promote continued learning.

Maintenance and audit of records:

The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM must be used for planning and recording continuing learning activities. The practitioner is required to retain in his or her records the **completed form with all supporting documentation** for a **period of four years** following the renewal of an active license.

The Board will periodically conduct a **random audit** of its active licensees to determine compliance. The practitioners selected for the audit must provide the completed CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and any supporting documentation within 30 days of receiving notification of the audit.

The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM

PART A: ACTIVITY

Learning Activity, Resources, Strategies & Experiences - List resources, strategies & experiences that you used to develop or maintain the selected knowledge or skill listed in Part B; e.g., conferences, continuing education courses, specialty certification, in-service workshops, consultations, discussions with colleagues, self-study courses, research in preparation for teaching, reading peer reviewed journals and textbooks, and self instructional media.

Date(s) of Activities - List the date(s) that you were engaged in the learning activity.

PART B: ASSESSMENT

Knowledge or Skills Maintained or Developed - Think about questions or problems encountered in your practice. Describe the knowledge or skills you addressed during the learning activity listed in Part A. Consider ethics, standards of care, patient safety, new medical technology, communication with patients, the changing health care system, and other topics influencing your practice.

HOURS/TYPE

Hours Actually Spent in Learning Activity: List the hours actually spent in the learning activity to nearest ½ hour. Total hours should be at least 20 hours biennially.

Types of Activities: List the type of activity from the categories described below:

Category 1 continuing learning activities

30 hours required biennially

1. Must be offered by a sponsor or organization which is recognized by the profession and which provides documentation of hours to the practitioner. A minimum of 30 of the 50 hours shall be in Category 1 activities approved by the ABGC, the ABMG or the NSGC and may include in-service training, self-study courses, continuing education courses, or professional workshops.

Category 2 continuing learning activities

10 hours required biennially

2. May or may not be approved by a sponsor or organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning. Category 2 activities may include practitioner activity credits, independent reading or research, consultation with another genetic counselor, preparation for a presentation or self-study through multi-media. No more than 20 of the 50 hours may be Category 2 activities.

PART C: OUTCOME

Outcome - Indicate whether you will: a) make a change in your practice, b) not make a change in your practice, and/or c) need additional information on this topic. (*You may include personal notes regarding the outcome of participating in this activity, e.g., learning activities you plan for the future, questions you need to answer or barriers to change.*)

CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM

Please photocopy this original form to record your learning activities.

The completed forms and all documentation must be maintained for a period of four years.

PART A: ACTIVITY		PART B: ASSESSMENT	# OF HOURS/TYPE		PART C: OUTCOME
Learning Activity, Resources, Strategies & Experiences; e.g. conferences, consultations, self-study courses, peer-reviewed journals, continuing education courses, specialty certification.	Date	Knowledge or Skills You Maintained or Developed. What questions or problems encountered in your practice were addressed by this learning activity?	Cat. 1 (10 hours) Sponsored by a professional organization	Cat. 2 (10 hours) Learner approved	Outcome: Indicate whether you will: a) make a change in your practice, b) not make a change in your practice, and/or c) need additional information on this topic.

This page should be completed at the end of your two year renewal cycle and inserted as the final page of your CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM.

Record all category 2 continuing learning activities you completed during the preceding two-year period of professional license. Recorded hours should indicate no more than 20 category 2 continuing education hours. The remaining category 1 hours may be included on this form, but you must maintain copies of certificates of completion for all category 1 hours. The CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and all documentation should be maintained in your records for six years.

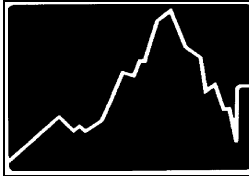
As you consider your completed CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM, please reflect upon your career and in the space below identify problems or questions you expect to address during the next biennial period of medical license renewal:

As required by law and regulation, I certify that I have completed the CONTINUED COMPETENCY ACTIVITY AND ASSESSMENT FORM and have participated in 50 hours of continuing education or learning activities as required for renewal of genetic counselor licensure in the Commonwealth of Virginia.

Signature

Date

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Genetic Counselor | <input type="checkbox"/> Osteopathy and Surgery | <input type="checkbox"/> Radiologic Technologist |
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> Medicine and Surgery | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Radiologic Technologist - Limited |
| <input type="checkbox"/> BCaBA | <input type="checkbox"/> Midwife | <input type="checkbox"/> Podiatry | <input type="checkbox"/> Radiologist Assistant |
| <input type="checkbox"/> BCBA | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Polysomnographic Technologist | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Occupational Therapist Assistant | | |



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Virginia Department of Health Professions

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Phone: (804) 367-4600
Fax: (804) 527-4426
Email: medbd@dhp.virginia.gov

Please provide name and address of setting/organization exactly as it appears on your application chronology.

Clearly print/type name of applicant

Name of Setting: _____

Address: _____

Last 4 of Social Security Number XXX-XX-_____

City, State, Zip: _____

The Virginia Board of Medicine, in its consideration of an applicant for licensure, depends on information from persons and institutions regarding the applicant's employment, training, affiliations, and staff privileges. Please complete this form to the best of your ability and return it to the Board by mail, fax or email so the information you provide can be given consideration in the processing of his/her application in a timely manner. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past, and present) and governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of my application.

Signature of Applicant _____

1. Date and type of service: This individual served with us as _____
from _____ to _____.
(Month/Year) (Month/Year)

2. Please evaluate: (Indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge				
Clinical judgment				
Relationship with patients				
Ethical/professional conduct				
Interest in work				
Ability to communicate				

3. Recommendation: (please indicate with check mark) Recommend highly and without reservation Recommend as qualified and competent
 Recommend with some reservation (explain) _____
 Do not recommend (explain) _____

4. Of particular value to us in evaluating any applicant are any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you. _____

5. The above report is based on: (please indicate with check mark)
 Close personal observation General impression A composite of evaluations
 Other: _____

Date (Required): _____

Signed by: _____

Print or type name: _____

Signator Contact Number: (_____) _____

Title: _____