MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777   800-492-6836
www.mbp.state.md.us

VERIFICATION OF PROFESSIONAL EDUCATION FOR
<u>SUPERVISED</u> GENETIC COUNSELOR LICENSURE

Part 1 | **APPLICANT: Complete Part 1 and send to the institution where you completed your Genetic Counselor program.**

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.)   First name   Middle name   Maiden Name

Date of Birth: _____/_____/_____   Social Security Number: _____- _____ - _____
mm   dd   yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____   Degree Received: _____
mm/yyyy

Applicant's Signature: _____   Date: _____

Part 2 | **REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please email the completed form to: mdh.mbpcredentials@maryland.gov.**

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

☐ Associate's Degree   ☐ Certificate   ☐ Bachelor's Degree   ☐ Master's Degree   ☐ Other:_____
(specify)

in _____.   The program was accredited by: _____
Educational Program   ACGC

_____   _____
Printed Name of Authorized Official   Name of Institution

_____ _____ _____
Title of Authorized Official   Telephone Number   Fax Number

_____   _____
Signature of Authorized Official   Date

SEAL

OF THE

INSTITUTION