## Affidavit and Authorization for Release of Information – Iowa Board of Medicine

**Applicant:** Sign this form in the physical presence of a notary public with an attached passport-quality color photo. **Mail this form directly to the Iowa Board of Medicine, 400 SW 8th Street, Suite C, Des Moines, IA 50309.**

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in the application for licensure in Iowa, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the application for licensure and I have personally answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice as a genetic counselor is granted to me by the Board.

I understand I am responsible for completing my own application for licensure in Iowa. My failure to complete my own application, failure to answer questions contained in the application truthfully and completely, or failure to sign this document in the physical presence of a notary may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice genetic counseling.

**Applicant Photograph**

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-quality color photo of yourself in this square.

_____

*Applicant's signature (must be signed in the physical presence of a notary. Notarization via webcam or any other method is not allowed.)*

_____

*Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)*

_____

*Date of signature (must correspond to date of notarization)*

**NOTARY**

Please note: The Notary Public seal should overlap the bottom of the photo to the left.

State of_____, County of_____,
I certify that on the date set forth below, the individual named above did appear physically before me and that I did identify this applicant by: (a) comparing his/her appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this ____ day of_____, 20____.

Notary Public Signature_____My Notary Commission Expires _____

**IOWA BOARD OF MEDICINE**
400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

## VERIFICATION OF ABGC or ABMGG CERTIFICATION

**Applicant:** Complete the top portion of this form and submit to the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics to verify your certification status.

**Verifying Agency:** Complete and return the form directly to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

It is hereby certified that _____
(Name of Applicant)

Was issued certification on _____
(Issue Date)

Expiration Date _____
(Expiration Date)

Any disciplinary action taken against this applicant's certification status?
Yes _____ No _____
**If yes,** provide details of the disciplinary action and a copy of any documentation related to the event.

Are there any pending complaints against this applicant's certification status?
Yes _____ No _____
**If yes,** provide details of the pending complaints and a copy of any documentation related to the event.

**Institutional Seal**

**(If your institution does not have an official seal, this form must be notarized.)**

**Completed by the Certifying Agency:**

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

**Authorization for Release of Information – Verification of ABGC or ABMGG Certification**

The applicant must sign this form and submit with the verification form. The certifying agency may retain this release of information for their records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Postgraduate training (internship, residency & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonable necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensing process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information".

_____ _____

Signature of Applicant Date

**PROHIBITION ON REDISCLOSURE**

**This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.**

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# VERIFICATION OF GENETIC COUNSELOR EDUCATION

**Applicant:** Complete the top portion of this form and submit to all the genetic counselor program(s) you have attended.

**Educational Institution:** Complete and return the form directly to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

It is hereby certified that _____
(Name of Applicant)

Matriculated in _____
(Name of School)

located at _____
(Address, City, State, Zip, Country)

From _____ To _____
(Month/Year) (Month/Year)

Date of Degree: _____ Type of Degree:_____

Was any disciplinary action ever taken against the applicant?
Yes _____ No _____
**If yes,** provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file?
Yes _____ No _____
**If yes,** provide details of the derogatory information and a copy of any documentation related to the event. *Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

**Institutional Seal**

**(If your institution does not have an official seal, this form must be notarized.)**

**Completed by the President, Secretary, Dean or Registrar:**

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

**Authorization for Release of Information – Verification of Genetic Counselor Education**
The applicant must sign this form and submit with the Verification of Genetic Counselor Education form. The educational institution may retain this release of information for their records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Postgraduate training (internship, residency & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonable necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensing process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____

Signature of Applicant Date

**PROHIBITION ON REDISCLOSURE**

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# VERIFICATION OF GENETIC COUNSELOR LICENSE/REGISTRATION/CERTIFICATION & ANY PROFESSIONAL LICENSE

**Applicant:** Complete the top portion of this form and submit to each regulatory agency that has issued you a genetic counselor license/registration/certification or any other professional license.

**Verifying Regulatory Agency:** Complete and return the form directly to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

It is hereby certified that _____
(Name of Applicant)

Was issued license/registration/certification number_____
(Number Issued)

On _____ By: _____
(Issue Date) (Issuing State Agency)

Expiration date of license/registration/certification number _____
(Expiration Date)

Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? Yes _____ No _____
**If yes,** provide details of the disciplinary action and a copy of any documentation related to the event.

Are there any pending complaints against this applicant's license? Yes _____ No _____
**If yes,** provide details of the pending complaints and a copy of any documentation related to the event.

Has the applicant voluntarily relinquished their credential? Yes _____ No _____
**If yes,** provide a letter of explanation.

**Institutional Seal**

**(If your institution does not have an official seal, this form must be notarized.)**

**Completed by the Regulatory Agency for the Credential:**

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

**Authorization for Release of Information – Verification of Genetic Counselor License/Registration/Certification or any Professional License**

The applicant must sign this form and submit with the verification form. The regulatory agency may retain this release of information for their records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Postgraduate training (internship, residency & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonable necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

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