**L**ouisiana **S**tate **B**oard of **M**edical **E**xaminers

630 Camp Street, New Orleans, LA 70130

Telephone: (504) 568-6820

Website: [**www.lsbme.la.gov**](http://www.lsbme.louisiana.gov)

**Registration as a Collaborating Physician for a Genetic Counselor**

**Online Education Course and Quiz**

To register as a collaborating physician (CP), you must take and successfully complete an online education course and quiz (when available). The course reviews the Rules pertaining to collaboration with Genetic Counselors. For information and Enrollment Key, email licensing at [licensing@lsbme.la.gov](mailto:licensing@lsbme.la.gov).

**Physician name** (Last, First, degree):       **License number:**

**Requirements** (see footnotes 1, 2, and 3) **Check Yes or No**

|  |  |  |
| --- | --- | --- |
| 1. I hold a license to practice medicine in Louisiana. | YES | NO |
| 1. I am actively engaged in the provision of direct patient care in this state practicing in an area comparable in scope, specialty, or expertise to that of a genetic counselor. | YES | NO |
| 1. I have read the Board Rules relating to GC’s as published on the LSBME web site (La Admin Code Title 46 Part XLV Chapters 38 and 60). | YES | NO |
| 1. I have established guidelines and protocols for the genetic counselor‘s practice in accordance with the standards of practice prescribed by LAC 46 XLV. §6019 –6021 of the board’s rules governing genetic counseling Collaborative Practice Agreements. | YES | NO |
| 1. I will work with and provide medical support to the genetic counselor in accordance with the Collaborative Practice Agreement and rules of the Board. | YES | NO |
| 1. I have no pending disciplinary proceedings before the board and practice in accordance with its rules. | YES | NO |
| 1. I acknowledge that in signing this application I am certifying to the truthfulness and authenticity of all information that is provided. | YES | NO |

**Exclusions** **Check Yes or No**

|  |  |  |
| --- | --- | --- |
| 1. Are you employed by, or receiving any financial payments from, a genetic counsellor for any services? (if yes, see footnote 3) | YES | NO |

**Checklist ✓**

* \_\_\_\_\_\_$75 registration fee enclosed
* \_\_\_\_\_\_Online education course certificate attached

**CP Signature** (no stamps):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address** (to notify you of approval) PRINT CLEARLY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Footnotes:

1. Collaborating Physicians are considered Supervising Physicians and must register once for a lifetime certification. A $75 fee is required and must accompany this application.
2. Questions 1 – 7 – a negative answer (no) must be accompanied by an explanation signed by the physician.
3. Question 8 - exceptions will be considered by the Board on a case by case basis if the independence of the physician in terms of exercising his or her supervisory responsibilities can be assured. Provide details relating to the practice arrangements on a continuation sheet.

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**Board Approval:** Licensing Analyst: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_ #CP.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_