Request for Credential Verification

Date: _____

Name of Genetic Counselor(s): _____

Name of Requestor (if different from above): _____

Requestor Company Name/State Licensure Board (for multiple state requests, please abbreviate requested states on **one** form on line below; ABGC has state board email and mailing addresses on file):

_____

Is a hard copy needed? ☐ yes ☐ no *(If no, the letter will be sent via email.)*

Mail To Address 1: _____

Address 2: _____

City, State, Zip: _____

Email to: _____

Fee waived for requests made by Diplomates (including new exam passers) in good standing with all current CMF payments.

$40 FEE REQUIRED per counselor verified for:

- **Third Party Requests**
- **Employer Requests**
- **Requests made by Diplomates not in good standing**

Method of payment:

☐ **Check** ☐ **Visa** ☐ **Master Card** ☐ **Discover** ☐ **American Express**

Check # _____

Card #: _____

Expiration Date: _____ **Total Charged:** _____

Name on Card: _____

Cardholder Signature: _____

Please email, fax or mail form to the ABGC Executive Office:
Email: info@abgc.net **Fax**: 913-222-8606 **Mail**: 4400 College Blvd., Ste 220, Overland Park, KS 66211
Phone: 913-222-8661 **Website**: www.abgc.net