Canadian Association of Genetic Counsellors

Association Canadienne des Conseillers en Génétique

Program Director Statement
Supplement for Student Applicants

SURNAME	FIRST NAME	INITIAL
DATE OF BIRTH (YY/MM/DD)		SEX (M/F)

PROGRAM TITLE:____

INSTITUTION NAME: ____

LOCATION (CITY, PROVINCE): ____

I__________________________________, GENETIC COUNSELLING PROGRAM DIRECTOR, CERTIFY THAT THE ABOVE-MENTIONED CANDIDATE WILL EITHER:

GRADUATE FROM THE EDUCATIONAL PROGRAM MENTIONED ABOVE BY jUNE 1ST OF THE EXAMINATION YEAR

WILL HAVE COMPLETED ALL ASPECTS OF THE PROGRAM BY THE EXAMINATION DATE AND WILL PROVIDE A 'CONFIRMATION OF ELIGIBILITY TO GRADUATE' LETTER FROM THE GRADUATE STUDIES OFFICE TO THE CERTIFICATION BOARD BY JULY 31ST OF THE EXAMINATION YEAR

SIGNATURE OF PROGRAM DIRECTOR__________________________________

DATE:

CAGC Certification Board
PO Box 52083,
Oakville, ON
L6J 7N5 CANADA