Guam Board of Allied Health Examiners

Health Professional Licensing Office

Department of Public Health & Social Services, 123 Chalan Kareta, Mangilao, Guam 96913.

Tel: 671--735-7412/08

Recent 2 X2 photo
(Less than 90 days)
SIGNED

DATE OF INITIAL APPLICATION or RENEWAL: _____

A.1.____Initial Application for Licensure: ____ **by State Endorsement** ____ **by Examination** (Fill out all sections below)	**A.2.____Renewal of Licensure** (Fill out appropriate sections fully & correctly. Update any change of addresses, phone numbers, and email) ***Notarize*** this Form required by §12824 (c) of the Allied Health Practice Act

(Check your discipline)

____ Acupuncture	____ Ind. Marr. & Fam. Therapy	____ Physical Therapy	____ Respiratory Therapy Tech.
____ Audiology	____ Nursing Home Admin.	____ PT Assistant	____ Speech-Language Pathology
____ Chiropractic	____ Nutritionist	____ Physician Assistant	____ Speech-Language Assistant
____ Clinical Psychology	____ Occupational Therapy	____ Podiatric Medicine	____ Veterinary Medicine
____ Clinical Dietitian	____ OT Assistant	____ Respiratory Therapy	____ Others:

B.1.____Application for Certificate	**B.2.____Application for Certification Renewal**
____ Euthanasia Technician	____ Euthanasia Technician
____ Others	____ Others

C.1.____Application for Registry	**C.2.____Application for Registry Renewal**
____ Speech Language Assistants	____ Speech Language Assistants
____ **Others**	____ **Others**

General Instructions: 1) Please print. 2) COMPLETE Form. 3) All FEES paid to the Treasurer of Guam are non-refundable. 3a) On-island applicants must pay the applicable fees to the Treasurer of Guam prior to submitting application/renewal form to the Health Professional Licensing Office. Receipt of payment must be attached to ***notarized*** Form. 3b) Off-Island applicants must pay the applicable fees with a Cashier's check payable to Treasurer of Guam. Attach cashier's check to the completed application or renewal form, ***notarized,*** and send to HPLO at the address shown above. 4) All required CE's for renewal must be received by HPLO no later than November 30th of each even numbered year for Board's consideration. (The GBAHE generally meets on the first Friday of the month.) 5) All licenses expire biennially on 31st December of each even numbered year. Any person who practices a healing art profession without a current valid license, shall be guilty of a misdemeanor upon the first offense and guilty of a felony for second and subsequent offenses. 6) Under the Allied Health Practice Act, there is no provision to issue a temporary or conditional license. 7) Applicants and Licensees are responsible for updating any change, in writing, to the Board. 8) Please refer to, available on-line, the Guam Compiler of Laws, 10 GCA Health and Safety; Chapter 12, Medical Practices Part I & II; Article 8 Allied Health Practice Act and disciplines from Article 9 to 22.

D. IDENTIFICATION:

NAME: _____ SOCIAL SECURITY #: _____
Last First Middle (Maiden)

ALL OTHER NAMES / ALIASES _____

Sex: M___ F ___ AGE: ____ Date of Birth: _____ Place of Birth: _____ Citizenship: _____ Residency: _____
(please show proof by birth certificate or U.S. Passport)

PERMANENT ADDRESS: _____

MAILING ADDRESS: _____

GUAM PRACTICE / CLINIC ADDRESS: _____

WORK PHONE: _____ HOME PHONE: _____ CELL PHONE: _____ Email: _____

E. EDUCATIONAL INFORMATION (initial applicantion): (Attach additional sheet if necessary)

Educational Information	Name/address of Institution	Date graduated	Degree/ Certificate
High School			
Under-graduate School			
Graduate School			
Post Graduate School			
Field Work Experience			
Post Graduate Training (Internship/ Residency)			
Others			

PLEASE CONTINUE ON REVERSE SIDE

F. PROFESSIONAL INFORMATION:

1. Professional Licenses: List all licenses from state(s), territory or foreign countries. Provide date/place of license issued. Indicate the status of license (current, suspended, revoked and /or lapsed.) Please state reason (attach additional sheet if necessary.)

FROM (DATE)	TO (DATE)	CLINIC LOCATION CITY, STATE	TYPE OF LICENSE/ STATUS	COMMENT OR REASON FOR LEAVING PRACTICE

2. Professional / Work History: List all places of professional employment. (Attach additional sheet if necessary)

FROM (DATE)	TO (DATE)	LOCATION CITY, STATE / COUNTRY	REASON FOR LEAVING EMPLOYMENT

3. Professional Memberships (List current membership/association)

FROM (DATE)	TO (DATE)	MEMBERSHIP / ASSOCATION

G. OTHER INFORMATION REQUIRED: (Please circle answer. If yes, please explain in detail in separate sheet.)

YES	NO	1) Have you ever been charged, arrested or convicted of a felony or gross misdemeanor?
YES	NO	2) Have you ever had a professional license placed on probationary status, put on restriction, denied, suspended, revoked by any licensing authority of Guam, another state, territory or foreign country?
YES	NO	3) Have you ever been reprimanded, disciplined, required to or asked to willingly surrender a license issued by a licensing authority of Guam, another state, territory or foreign country?
YES	NO	4a) Have you ever been found guilty or entered a plea of nolo contendere to any administrative charge or legal offense in connection with your practice? 4b) Have you ever had any professional legal action taken, torts, or malpractice settlements?
YES	NO	5) Do you use any chemical substance(s) which in any way impairs or limits your ability to practice with reasonable skills and safety?
YES	NO	6a) Do you have any medical/physical, mental, or substance-related disorders that may interfere with your ability to competently, independently and safely perform the essential functions of your profession? If yes, attach a statement by your primary physician summarizing your limitation.
YES	NO	6b) Are you receiving any ongoing treatment (with or without medication)?
YES	NO	6c) Are you participating in any monitoring program for any of the above?
YES	NO	7) Do you have any outstanding child support, spousal support, alimony or educational loan payment or repayment obligation of 90 days or more in Guam or in any state, territory, or foreign country? **(Guam 5GCA Section 3402 (B)**
YES	NO	a. I am not more than ____ days delinquent in complying with child support order, alimony order or educational loan payment obligations;
YES	NO	b. I am more than____ days delinquent in complying with child support order, spousal support order, alimony order or educational loan repayment obligations;
YES	NO	c. I am currently under order for child support, spousal support, alimony or educational loan payment obligations.
YES	NO	8) Do you have any moral or professional indiscretion that would interfere with your ability to practice?

I attest that all answers above are true. I am responsible for familiarizing myself with 10 GCA, Chapter 12, Article 8 and my discipline's article, and that I will comply with my national association's Code of Ethics and Code of Conduct as indicated by my signature. I also declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT or LICENSEE: _____ DATE: _____

(Signed before a Notary Public)

TO BE SWORN BEFORE AN OFFICIAL AUTHORIZED TO ADMINISTER OATHS.

H. AFFIDAVIT:

BEING DULY SWORN, SAYS HE/SHE IS THE PERSON REFERRED TO IN THIS APPLICATION. THE STATEMENTS MADE ARE TRUE IN EVERY RESPECT.

SUBSCRIBED AND SWORN TO BEFORE ME THIS_____ DAY OF_____, 20____.

NOTARY PUBLIC: _____ NOTARY PUBLIC: _____

(Please print NAME) (Signature)

MY COMMISSION EXPIRES: _____

(Date)

NOTARY PUBLIC SEAL:

Guam Board Of Allied Health Examiners

ENDORSEMENT VERIFICATION

PART A – INSTRUCTIONS

1. Applicant completes Part B. Type or Print.
2. Send this form to your state of original licensure (include required processing fee.)
3. Your state of original license will return this form **directly** to the address indicated below.

PART B – TO BE COMPLETED BY APPLICANT

1. CURRENT NAME: _____
   Last *First* *Middle*

2. NAME AS IT APPEARS IN ORIGINAL LICENSE:
   _____
   Last *First* *Middle*

3. DATE OF BIRTH: _____ PLACE OF BIRTH: _____ SSN: _____

4. CURRENT ADDRESS: _____
   Street or P.O. Box # *City* *State* *Zip Code*

5. LICENSE INFORMATION:

   State of Original License: _____ Original License No.: _____ Date Issued: _____

I HEREBY AUTHORIZE THE LICENSING AUTHORITY TO FURNISH THE BOARD OF ALLIED HEALTH EXAMINERS THE REQUESTED INFORMATION CONTAINED IN PART-C.

_____ _____
Signature *Date*

PART C – TO BE COMPLETED BY LICENSING AUTHORITY

1. Original License to practice as: _____ Expiration Date: _____

   License Number: _____ Date Issued: _____

   License Status: Active _____ Inactive _____ Lapsed _____

2. Licensed by: Examination _____ Endorsement _____
   Name of Exam *State*

PLEASE CONTINUE ON REVERSE SIDE

Public Health Center | 123 Chalan Kareta Street, Mangilao GU 93913

3. Was the license ever encumbered in any way, revoked, suspended, surrendered, restricted, limited, or placed on probation?

   Yes _____ No _____. If yes, please explain on a separate sheet.

4. Name of school: _____

   Address: _____
   Street or P.O. Box # *City* *State* *Zip Code*

   Type of Program: _____Associate Degree _____ Baccalaureate_____ Doctorate:_____

   _____ Diploma _____ Masters in: _____

5. Major/Minor: _____ Date of Graduation:_____

6. Was the school approved or accredited at the time of applicant's enrollment?

   Yes _____ No _____

   Approved by whom: _____

I CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION PROVIDED IS TRUE, AND ATTEST TO THE TRUTH AND ACCURACY OF STATEMENTS, ANSWERS AND REPRESENTATIONS MADE IN SUPPORT OF THE ABOVE NAMED APPLICANT SEEKING LICENSE TO PRACTICE IN GUAM.

SIGNATURE: _____

TITLE: _____

STATE: _____

DATE: _____

BOARD

SEAL

GBAHE-6 (Rev. 7/2006)