Guam Board of Allied Health Examiners

Health Professional Licensing Office
Department of Public Health & Social Services
194 Hernan Cortes Avenue
213A Terlaje Building
Hagåtña, GUAM 96913
Tel: 671-735-7408

APPLICATION FORM FOR INITIAL LICENSE

General Instructions:

a. Please type or print legibly.

b. Submit a recent (not more than 90 days old) 2" x 2" photograph.

c. Applications for Licensure Form(s) must be notarized. *See*, 10 GCA § 12824(c).

d. Attach a signed Authorization for Release of Employment Records.

e. All FEES paid to the Treasurer of Guam are non-refundable.

    1. 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 this Application Form.

    2. Off-Island applicants must pay the applicable fees with a Cashier's check payable to Treasurer of Guam. Attach cashier's check to this completed application and send to HPLO at the address shown above.

f. The Allied Health Practice Act does not provide for the issuance of temporary or conditional licenses.

g. Undergraduate and graduate transcripts, certifications, and verification of licensure by other jurisdictions, are to be sent directly from the educational institution and licensing agency to the Board. Copies of transcripts or licenses delivered by the applicant are not acceptable.

h. Applicants and Licensees are responsible for updating any change in the information provided in their application, in writing, to the Board.

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INITIAL LICENSE APPLICATION

Attach Recent 2" X 2" Photo
(Not More than 90 Days Old)

A. Date of Application: _____ **By Endorsement** ☐ **By Examination** ☐

B. IDENTIFICATION:

NAME: _____
Last First Middle (Maiden)

OTHER NAMES / ALIASES_____

Sex: M☐ F☐ AGE: ____ Date of Birth: _____ Citizenship: _____ SOCIAL SECURITY #:_____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____

CURRENT PRACTICE / CLINIC ADDRESS: _____
(Any change of office/clinic/practice address must be reported promptly to the Board)

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

C. Discipline for Which You Are Seeking License, Certification, or Registration:

- ☐ Acupuncture
- ☐ Audiology
- ☐ Chiropractic
- ☐ Clinical Psychology
- ☐ Licensed Mental Health Counselor
- ☐ Licensed Professional Counselor
- ☐ Marriage & Family Therapist
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Occupational Therapy Assistant
- ☐ Physical Therapy
- ☐ Physical Therapy Assistant
- ☐ Podiatric Medicine
- ☐ Physician Assistant
- ☐ Respiratory Therapy (Registered)
- ☐ Respiratory Therapy (Certified)
- ☐ Speech Language Pathology
- ☐ Nutritionist/Clinical Dietitian
- ☐ Veterinary Medicine

D. EDUCATIONAL INFORMATION:

Attach additional sheets if necessary. **Note**: Transcripts must be sent directly from the educational institution.

Educational Information	Address of Institution	Date Graduated	Degree/ Certificate
High School			
Undergraduate School			

Graduate School			
Post Graduate School			
Field Work Experience			
Post Graduate Training (Internship/ Residency)			
Others			

E. PROFESSIONAL INFORMATION:

1. Professional Licenses: List all licenses from any state(s), territory or foreign countries. Provide date, place, type, and license number of license issued. Indicate the present status of license (active, inactive, suspended, revoked, or lapsed). Attach additional sheets if necessary.

FROM (DATE)	TO (DATE)	STATE, TERRITORY, COUNTRY	TYPE OF LICENSE / LICENSE # / STATUS	REASON FOR LEAVING PRACTICE

2. Professional / Work History: List all places of professional employment since you have been licensed, completed your professional education, or 15 years, whichever is longest. Attach additional sheets if necessary. Initial applicants are required to provide a signed and notarized (otherwise blank) AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS.

FROM (DATE)	TO (DATE)	JOB TITLE	EMPLOYER NAME STREET ADDRESS	CITY, STATE ZIP CODE	TELEPHONE NO.	REASON FOR LEAVING

FROM (DATE)	TO (DATE)	JOB TITLE	EMPLOYER NAME STREET ADDRESS	CITY, STATE ZIP CODE	TELEPHONE NO.	REASON FOR LEAVING

3. Professional Memberships: List current membership in any professional association. (Attach additional sheets if necessary)

FROM (DATE)	TO (DATE)	MEMBERSHIP / ASSOCIATION	LOCATION IF NOT NATIONAL

F. ADDITIONAL PERSONAL INFORMATION :

Detailed Chronological History (required by 10 GCA § 12805(a)(8))**:** Please provide the addresses and dates of residence since graduation from high school. Attach additional sheets if necessary.

FROM (DATE)	TO (DATE)	PHYSICAL & MAILING ADDRESS

G. OTHER INFORMATION REQUIRED: Please check answer. If yes to any question, explain *in detail* separately and attach. For questions 1, 3 through 7, and 10, include copies of the complaint or other charging instrument and the final disposition of the matter.

YES	NO	1) Have you ever been charged, arrested, or convicted of a felony or any other offense involving moral turpitude?
YES	NO	2) Has any state, territory, or foreign country rejected or denied your application for licensure or certification in any profession?
YES	NO	3) Have you ever had a professional license or certificate placed on probationary status, put on restriction, suspended, refused to renew, or revoked by any licensing authority in Guam, or another state, territory, or foreign country?
YES	NO	4) Have you ever been reprimanded, disciplined, or required or asked to surrender a professional license issued by a licensing authority in Guam, another state, territory, or foreign country?
YES	NO	5) Have you ever voluntarily surrendered your license or certificate in any profession in order to avoid disciplinary action by any licensing or regulatory agency in any state, territory, or foreign country?
YES	NO	6) Have you ever been sanctioned or otherwise disciplined by a professional association?
YES	NO	7a) Have you ever been sued for malpractice or other professional liability claim made against you?
YES	NO	7b) Has there been any adverse judgment against you, or settlement by you or made on your behalf as a result of litigation or threatened litigation arising from a professional liability claim against you?
YES	NO	8a) 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	8b) Are you receiving any ongoing treatment (with or without medication)?
YES	NO	8c) Are you participating in any monitoring program for any of the above?
YES	NO	9) 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? *See*, 5 GCA § 34213.
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	10) Have you ever been judged incompetent by a court of law?

I declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief. I acknowledge that I am responsible for familiarizing myself with Guam law, including but not limited to Title 10 Guam Code Annotated, Chapter 12, Article 8 and my profession's article, and for notifying the GBAHE within thirty (30) days if any information provided in herein should change.

_____ DATE: _____

SIGNATURE OF APPLICANT

TO BE SWORN TO OR AFFIRMED BEFORE AN OFFICIAL AUTHORIZED TO ADMINISTER OATHS

_____, being duly sworn, says that he or she is the person referred to in the foregoing application and that the statements made therein are true.

Subscribed and Sworn to Before Me this_____ day of_____, 20____.

NOTARY PUBLIC: _____

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

Employee's Name: _____

Date of Birth: _____ Social Security No. _____

TO: **_____** (to be completed by GBAHE)

_____

_____

_____

The employee identified above and whose signature appears below has filed an application for licensure before the Guam Board of Allied Health Examiners. You have been identified by this individual as a present or former employer. By copy of this Authorization for Release of Employment Records, signed by this present or former employee below, you are hereby authorized to disclose, make available upon request, and furnish to:

The Guam Board of Allied Health Examiners, their agents, representatives, and attorneys,

all records, including confidential personnel files, regarding this individual's employment with your organization.

A facsimile, photocopy, or scanned image of this authorization shall also authorize you to release the records herein.

I declare under penalty of perjury that the foregoing is true and correct.

_____
Signature of Employee (Date)

_____
Print or Type Name