**GUAM BOARD OF ALLIED HEALTH EXAMINERS**
**Health Professional Licensing Office**
213 Terlaje Bldg., 194 Hernan Cortez Ave. Hagatna, Guam 96910

**Requirements for Podiatric Medicine (10GCA, Chapter 12, Article 8 & 17)**

GENERAL REQUIREMENTS (Article 8)

1. List all jurisdictions in the U.S. or foreign country where licensed or has applied for licensure to practice (See Application Form);
2. All official graduate transcripts must be sent directly to the Board;
3. Three (3) letters of recommendation, original or notarized copies, one (1) of which must be a letter provided by your immediate supervisor of your most recent employer or by a practice associate, if you are in private practice, sent directly to the Board;
4. Police clearance from the Guam Police Department (GPD) if you have resided on Guam for more than one (1) year, or a police clearance from your last place of residence;
5. Submit any other information or documentation that the Board determines necessary.

Qualifications for PODIATRIC MEDICINE (Article 17)

1. Proof of Graduation from an approved college of podiatric medicine accredited by the Council on Podiatric Medical Education (CPME) of the American Podiatry Association (APA);
2. Proof of satisfactorily completed a (CPME) hospital-approved pediatric residency program with verification sent directly to the Board; and
3. Three (3) letters from doctors of podiatric medicine verifying that the applicant is competent, sent directly to the Board.
4. Application by endorsement from any U.S. jurisdiction:
5. Notarized copy of the applicant's license to practice podiatric medicine in that jurisdiction; and
6. An affidavit from the board of podiatric medicine examiners of any jurisdiction verifying the number of years that the applicant has been engaged in the legal and reputable practice of podiatric medicine in that jurisdiction.

# Guam Board of Allied Health Examiners
Health Professional Licensing Office
Department of Public Health & Social Services
194 Hernan Cortez Ave.
Terlaje Prof. Bldg. Ste. 213
Hagåtña, GU 96910-5052
Tel: 671-735-7409~12


# 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 (signed at back).

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" (signed at the back) 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:

- ☐ 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 (SLP)
- ☐ SLP Assistant (Bachelor's)
- ☐ SLP Assistant (Master's)
- ☐ 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

# Guam Board of Allied Health Examiners

**194 Hernan Cortez Ave.,Terlaje Prof. Bldg. Ste.213 Hagåtña, Guam 96910-5052**

## CERTIFICATE OF EDUCATION

THE APPLICANT BELOW IS APPLYING FOR A LICENSE TO PRACTICE IN GUAM. PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN **DIRECTLY** TO THE BOARD OF ALLIED HEALTH EXAMINERS AT THE ADDRESS ABOVE.

**PART A – TO BE COMPLETED BY APPLICANT:**

CURRENT NAME: _____
*(Last Name)* *(First Name)* *(Middle)*

PREVIOUS NAME USED: _____
*(Last Name)* *(First Name)* *(Middle)*

SOCIAL SECURITY NO.: _____

1. AREA OF SPECIALTY/PROFESSION: *(CHECK ONE)*

| | | |
|---|---|---|
| ☐ Acupuncture | ☐ Marriage & Family Therapist | ☐ Respiratory Therapy (Registered) |
| ☐ Audiology | ☐ Nursing Home Administrator | ☐ Respiratory Therapy (Certified) |
| ☐ Chiropractic | ☐ Nutritionist/Clinical Dietitian | ☐ Speech Language Pathology (SLP) |
| ☐ Clinical Psychology | ☐ Occupational Therapy | ☐ SLP Assistant (Bachelor's) |
| ☐ Euthanasia Technician (Certified) | ☐ Occupational Therapy Assistant | ☐ SLP Assistant (Master's) |
| ☐ Licensed Mental Health Counselor | ☐ Physical Therapy | ☐ Nutritionist/Clinical Dietitian |
| ☐ Licensed Professional Counselor | ☐ Physical Therapy Assistant | ☐ Veterinary Medicine |

I HEREBY AUTHORIZE RELEASE OF A COPY OF MY ACADEMIC RECORD TO THE BOARD

_____ _____
*SIGNATURE OF APPLICANT* *DATE*

**PART B – TO BE COMPLETED BY THE SCHOOL ADMINISTRATOR: Indicate (X) where applicable.**

1. NAME OF APPLICANT: _____
*(Last Name)* *(First Name)* *(Middle)*

2. NAME AND ADDRESS OF COLLEGE/UNIVERSITY: _____
*(Name)*
_____
*(Address)*

3. WAS THE SCHOOL BOARD-APPROVED OR STATE REGULATOR AGENCY-APPROVED DURING THE APPLICANT'S ENROLLMENT? ( ) YES ( ) NO
IF YES, BY WHOM: _____

4. THE APPLICANT ENTERED THE EDUCATION PROGRAM ON _____ AND COMPLETED _____ MONTHS ON _____.

5. NUMBER OF THEORY HOURS _____: NUMBER OF SUPERVISED CLINICAL/FIELDWORK HOURS _____.

6. WAS APPLICANT A GRADUATE FROM HIGH SCHOOL? _____ YES _____ NO; EQUIVALENT _____

7. ATTACHED IS THE OFFICIAL COPY OF APPLICANT'S TRANSCRIPT.

SEAL OF SCHOOL

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

# Guam Board of Allied Health Examiners

**194 Hernan Cortez Ave.,Terlaje Prof. Bldg., Ste.213 Hagåtña, Guam 96910-5052**

## VERIFICATION OF INTERNSHIP

THE APPLICANT BELOW IS APPLYING FOR A LICENSE TO PRACTICE IN GUAM. PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN **DIRECTLY** TO THE BOARD OF ALLIED HEALTH EXAMINERS AT THE ADDRESS ABOVE.

**PART A – TO BE COMPLETED BY APPLICANT:**

CURRENT NAME: _____
*(Last Name)* *(First Name)* *(Middle)*

PREVIOUS NAME USED: _____
*(Last Name)* *(First Name)* *(Middle)*

AREA OF SPECIALTY/PROFESSION: _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION TO THE GUAM BOARD OF ALLIED HEALTH EXAMINERS RELATIVE TO MY COMPLETION OF THE INTERNSHIP PROGRAM

_____ _____
*SIGNATURE OF APPLICANT* *DATE*

**PART B – TO BE COMPLETED BY THE INSTITUTION:**

1. NAME OF APPLICANT: _____
*(Last Name)* *(First Name)* *(Middle)*
2. NAME OF INSTITUTION _____
3. ADDRESS OF INSTITUTION ON _____
*(Street or PO Box #)*
_____
*(City)* *(State)* *(Zip Code)*
4. THE ABOVE NAMES APPLICANT SERVED HIS/HER INTERNSHIP PROGRAM FROM _____ TO _____
*(Date)* *(Date)*
FOR A TOTAL OF _____ MONTH(S), _____ YEAR(S).
5. THIS APPLICANT WAS SUPERVISED BY: _____
*(Name of Supervisor)* *(Profession/Specialty)* *(License No.)*
6. DURING THIS PERIOD SAID APPLICANT'S PERFORMANCE WAS: ___ Satisfactory and without filed complaints
___ Unsatisfactory – please explain on separate sheet

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.

SEAL

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

# Guam Board of Allied Health Examiners

**194 Hernan Cortez Ave.,Terlaje Prof. Bldg., Ste.213 Hagåtña, Guam 96910-5052**

## ENDORSEMENT VERIFICATION

**PART A – INSTRUCTIONS**

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

**PART B – TO BE COMPLETED BY APPLICANT:**

1. CURRENT NAME: _____
   *(Last Name)* *(First Name)* *(Middle)*
2. NAME AS IT APPEARS ON ORIGINAL LICENSE:

   _____
   *(Last Name)* *(First Name)* *(Middle)*
3. AREA OF SPECIALTY/PROFESSION: _____
4. DATE OF BIRTH: _____ PLACE OF BIRTH: _____ SSN: _____
5. CURRENT ADDRESS: _____
   *(Street or PO Box #)* *(City)* *(State)* *(Zip Code)*
6. LICENSE INFORMATION: Sate 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 OF APPLICANT* *DATE*

**PART C – TO BE COMPLETED BY LICENSING AUTHORITY.**

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

   License No.: _____ Date Issued: _____

   License Status: ___ Active ___ Inactive Years Lapsed: _____
2. License By: _____ Examination _____ Endorsement
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.

**PLEASE CONTINUE ON OTHER SIDE**

# Guam Board of Allied Health Examiners

**194 Hernan Cortez Ave.,Terlaje Prof. Bldg., Ste.213 Hagåtña, Guam 96910-5052**

***(Endorsement Verification cont'd)***

4. Name of School: _____

   Address: _____

   *(Street or PO Box #)* *(City)* *(State)* *(Zip Code)*

   Type of Program: _____ Associates 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, ANSWES AND REPRESENTATIONS MADE IN SUPPORT OF THE ABOVE NAMED APPLICANT SEEKING LICENSE TO PRACTICE IN GUAM.

***BOARD***

***SEAL***

_____
Name and Title of Certifying Person

_____
Signature

_____
Name of State

_____
Date

# Guam Board of Allied Health Examiners

194 Hernan Cortez Avenue
Terlaje Professional Building, Suite 213
Hagåtña, Guam 96910-5052

## RECORD OF PAYMENT

**I. IDENTIFICATION:**

Name:_____
(Last Name) (First Name) (M.I.)

**II. VERIFICATION OF LICENSURE:** If you are requesting verification, please print your complete name used on your original Guam License.

Name on Original License:_____

License #:_____ Signature:_____ Date:_____

**III. FEE:** Fees paid are **NON-REFUNDABLE**. Make check or money order payable to **TREASURER OF GUAM**.

| | | Initial Application | Biennial Application |
|---|---|---|---|
| 1. | Acupuncture and Oriental Medicine | $350 | $250 |
| 2. | Audiology | $250 | $200 |
| 3. | Chiropractic | $350 | $250 |
| 4. | Clinical Psychology | $350 | $250 |
| 5. | Psychology Associate | $200 | $150 |
| 6. | Licensed Professional Counselor | $250 | $200 |
| 7. | Licensed Professional Counselor Intern | $200 | $150 |
| 8. | Licensed Mental Health Counselor | $300 | $250 |
| 9. | Licensed Mental Health Counselor Intern | $200 | $150 |
| 10. | Marriage and Family Therapist | $300 | $250 |
| 11. | Marriage and Family Therapist Intern | $200 | $150 |
| 12. | Occupational Therapist | $250 | $200 |
| 13. | Occupational Therapist Assistant | $200 | $100 |
| 14. | Physical Therapy | $300 | $250 |
| 15. | Physical Therapy Assistant | $200 | $100 |
| 16. | Speech-Language Pathologist | $300 | $250 |
| 17. | Speech-Language Assistant | $200 | $150 |
| 18. | Respiratory Therapist | $250 | $200 |
| 19. | Certified Respiratory Therapist | $200 | $100 |
| 20. | Veterinary Medicine | $350 | $250 |
| 21. | Nursing Home Administrator | $250 | $200 |
| 22. | Nutritionist | $300 | $250 |
| 23. | Clinical Dietician | $200 | $100 |
| 24. | Euthanasia Technician (Annual) | $150 | $100 |
| 25. | Examinations When Required by Law or Rule | $250 | $250 |
| 26. | Application for Prescriptive Authority | $250 | $250 |
| 27. | Late Renewal Penalty (Up to One Year) | | $100 |
| 28. | Late Renewal Penalty (One Year and a Day to Two Years) | | $200 |
| 29. | Late Renewal Penalty (Two Years and a Day to Three Years) | | $300 |
| 30. | Late Renewal Penalty (Three Years and a Day to Four Years) | | $400 |
| 31. | Name Change Certificate Request | | $100 |
| 32. | Replacement (Lost) Identification Card | | $100 |
| 33. | Reinstatement of Suspended License | | $300 |
| 34. | Petition for Reinstatement of Expired License | | $500 |
| 35. | Petition for Reinstatement of Revoked License | | $500 |
| 36. | Verification of Guam License (Certificate of Good Standing) | | $50 |
| 37. | Inactive License | | one-half (1/2) the renewal fee |
| 38. | Returned Check Fee | | $40 |
| 39. | Other (Balance) | | $_____ |

**NOTE:** Please make a copy for Treasurer of Guam and return this original Form to HPLO/GBAHE with your receipt of payment. For off-island Applicants or Licensees, please enclose this form with your application and make check or money order payable to "Treasurer of Guam".

**FOR GUAM BOARD OF ALLIED HEALTH EXAMINERS OFFICE USE ONLY:**

PAYMENT TYPE: ( ) Check ( ) Money Order ( ) Cash ( ) Credit Card

FIELD RECEIPT #:_____ DATE PAID:_____