GUAM BOARD OF ALLIED HEALTH EXAMINERS
Health Professional Licensing Office
Current Physical Address:**194 Hernan Cortez Ave., Terlaje Prof. Bldg. Ste. 213 Hagåtña, Guam 96910-5052**

Requirements for Licensed Professional Counselor (LPC), Licensed Mental Health Counselor (LMHC), and Marriage & Family Therapist (MFT) (10 GCA, Chapter 12, Article 8 and Public Law 32-054)

GENERAL REQUIREMENTS.

___ 1. List all jurisdictions in the U.S. or foreign country where licensed or has applied for licensure to practice (§12805 (a) (4)(See Application Form);
___ 2. Document detailed chronological life history, including dates and places of residence (§12805 (a) (8));
___ 3. Document detailed employment history, including military service in the U.S. or foreign country (§12805 (a) (8));
___ 4. Document detailed educational history, including places, institutions, dates and program descriptions (§12805 (a)(7));
___ 5. All official graduate transcripts must be sent directly to the Board (§12805 (a);
___ 6. 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 (§12805 (b)(3)), sent directly to the Board;
___ 7. 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 (§12805 (b)(4);
___ 8. A set of fingerprints (paid by the applicant) and a sample of handwriting, ***if*** requested by the Board*; and*
___ 9. Any other information or documentation that the Board determines necessary (§12805 (a)(10)
___10. Submit to a physical, mental or professional competency examination, or a drug dependency evaluation, ***if*** deemed necessary by the Board.

QUALIFICATIONS FOR SPECIFIC DISCIPLINE

Licensed Professional Counselor (LPC)

___ 1. A doctorate or master's degree from an accredited school in the U.S. or Territory.
___ 2. A minimum of three thousand (3,000) hours of *documented** client service, of post- graduate experience under the supervision of a LPC, Clinical Psychologist or Psychiatrist.

REQUIREMENT OF 3,000 CLINICAL HOURS*

Face to face contact of
Individual,
Couple, and
Family;
Direct supervision (minimum of
Case conference (minimum of

*Applicant must complete the GBAHE established *Clinical Hours FORM*

GUAM BOARD OF ALLIED HEALTH EXAMINERS

LPC, LMHC, MFT 3000 CLINICAL HOURS FORM

NAME OF APPLICANT: ____________________ Clinic/Office Location/Address: ________________________

NAME OF DIRECT SUPERVISOR: _______________________ Discipline/License No.: ____________________

NAMEOF ALTERNATE SUPERVISOR: _____________________ Discipline/License No.: __________________

Please Print

DATE	TIME From/To	Hrs. Claimed	Type of Contact Individual/Marriage/Family	Presenting Problem One to three words	Supervised Hrs.

TOTAL HOURS: ________

I do attest that I have completed the supervised hours claimed.

Signature of Applicant: ______________________________ Date: ____________

I do attest that I have provided the required supervised hours.

Signature of Supervisor: ______________________________ Date: ____________ Page 1 of __ pages

>>>> Please duplicate additional pages as needed <<<<

Licensed Mental Health Counselor

1. A doctoral or Master's Degree from an accredited school in the U.S. or Territory;
2. Pass the National Clinical Mental Health Counselor Examination (NCMHCE);
3. Document evidence of one thousand (1,000) hours of post Masters clinical work in diagnostic and treatment planning.

Marriage and Family Therapist

1. A doctoral or Master's Degree from an accredited school in the U.S. or Territory.
2. Pass the National Clinical Mental Health Counselor Examination (NCMHCE).

QUALIFICATIONS FOR INTERN LICENSE

1. Mental Health Counselor Intern License

2. Marriage and Family Therapist Intern License

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, GUAM 96910
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.

Guam Board of Allied Health Examiners

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Department of Public Health & Social Services
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Tel: 671-735-7409-12

INITIAL LICENSE APPLICATION

Attach Recent 2" X 2" Photo Signed at the back (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
- ☐ 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
Health Professional Licensing Office
194 Hernan Cortez Ave., Terlaje Prof. Bldg. Ste.213, Hagåtña, GUAM 96910-5052

APPLICATION TO SIT FOR

_____ National Board for Certified Counselors (NBCC) for ***Licensed Professional Counselor (LPC)***
_____ National Mental Health Clinical Counselor Exam for ***Licensed Mental Health Counselor (LMHC)***
_____ Marriage & Family Therapist specialist exam for ***Marriage & Family Therapist (MFT)***

GENERAL INFORMATION:

The Guam Board of Allied Health Examiners has the sole authority to determine a Candidate's eligibility to take the examination(s).

Recent Photo 2x2 Less than 90 days, Signed/Dated at back of photo

A. IDENTIFICATION:

1. NAME: _____
   Last First Middle Maiden
2. SOCIAL SECURITY NUMBER: _____ 3. SEX: _____
4. DATE OF BIRTH: _____ 5. PLACE OF BIRTH: _____
   City State
6. PERMANENT ADDRESS: _____
7. MAILING ADDRESS: _____
8. TELEPHONE: _____ _____ _____ 9. Email: _____
   Work Cell Home

B. POST GRADUATE/ DOCTORAL INFORMATION:
Please provide a copy of Graduate School Transcript for verification (a requirement)

College/University: _____
Address: _____
Date Graduated: _____ Degree received: _____

_____ _____
(Signature of Applicant) **(Date)**

C. Approved by Board Member:

_____ _____
(NAME) (SIGNATURE) (DATE)

D. ID # Assigned: _____ (for Examination Purpose)

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	☐ Physician Assistant
☐ Audiology	☐ Nursing Home Administrator	☐ Podiatric Medicine
☐ Chiropractic	☐ Nutritionist/Clinical Dietitian	☐ Respiratory Therapy (Certified)
☐ Clinical Psychology	☐ Occupational Therapy	☐ Respiratory Therapy (Registered)
☐ Euthanasia Technician (Certified)	☐ Occupational Therapy Assistant	☐ Speech Language Asst (Registered)
☐ Licensed Mental Health Counselor	☐ Physical Therapy	☐ Speech Language Pathology
☐ 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 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:_____