



Department of Public Health & Social Services
GUAM BOARD OF EXAMINERS FOR DENTISTRY
194 Hernan Cortez Avenue Terlaje Professional Building, Suite 213
Hagåtña, Guam 96910
Website: <https://guamhplo.org>
Contact No. (671) 735-7404-12

REQUIREMENTS FOR DENTAL OFFICE PERSONNEL

All persons wishing to be Licensed as Dental Hygienist, or Certified as Dental Auxiliaries, Dental Assistants or Dental Lab Technicians must file an application with the Guam Board of Examiners for Dentistry (GBED), secure employment and be issued a Temporary Permit prior to employment start date. A Temporary Permit is valid for sixty (60) calendar days.

Applications must be accomplished by the payment of a non-refundable fee of fifty (\$50.00) Dollars.

DENTAL HYGIENIST

1. Successfully complete the GBED application form for Dental Hygienists.
2. Must document successful completion of a Dental Hygiene Training Program accredited by the American Dental Association (ADA) by attaching a notarized copy of the diploma.
3. Must document that they are currently licensed as a Dental Hygienist in one of the States. Submit a notarized copy of their state license.
4. The GBED may require a clinical examination for licensure of any applicant at the discretion of the Board.
5. Must successfully pass the GBED Jurisprudence Examination.
6. Copy of U.S. Passport or Driver's License and Police Clearance.

DENTAL AUXILIARIES

1. Successfully complete the GBED application form for Dental Auxiliaries.
2. Applicants must submit documentation, satisfactory to the Board, that they have completed a Dental Auxiliary Training Program equivalent to or greater in scope than that offered by the University of Guam in its most recent Dental Auxiliary Program.
3. A copy of the transcript, bearing the seal of the institution, must be forwarded directly to the Board by the school of university.
4. Copy of U.S. Passport or Driver's License and Police Clearance.

DENTAL ASSISTANTS

1. Successfully complete the GBED application form for Dental Assistants
2. Copy of U.S. Passport or Driver's License and Police Clearance

DENTAL LAB TECHNICIANS

1. Successfully complete the GBED form for Dental Lab Technicians
2. Copy of U.S. Passport or Driver's License and Police Clearance.



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APPLICATION FOR DENTAL ANCILLARY PERSONNEL

2" X 2" Photo

 Photo must be signed
 and dated on the back

 Name (Print) Age Gender

 Date of Birth Place of Birth

 Mailing Address

 Residence Address

APPLYING FOR:

- Dental Hygienist
- Dental Auxiliary
- Dental Assistant
- Dental Lab Technician

 Email Address Social Security No.

 Cell Phone No. Home Phone No. Work Phone No.

EDUCATION:

	DATE	DEGREE
HIGH SCHOOL		
COLLEGE/UNI		
DENTAL TRAINING		

Licensed to practice in which states, territories or foreign countries. Give date and place license issued. Give statement regarding any disciplinary actions or investigations on a separate sheet.

PROFESSIONAL EXPERIENCE:

FROM	TO	LOCATION	TYPE OF PRACTICE	REASON FOR LEAVING

EMPLOYMENT INFORMATION:

Have you secured employment? () Yes () No Signature of dentist employer: _____
 Expected date of employment: _____ Printed name of dentist: _____

TEMPORARY PERMIT:

Date of issue: _____ Temporary Permit #: _____ Category: _____
 Date of payment: _____ Amt & type of pymt: _____ Rec'd by: _____

A copy of this completed application will serve as your temporary certificate or license. Valid for sixty (60) days from date of issue.



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QUESTIONNAIRE FOR DENTAL EMPLOYMENT

Please indicate **YES** or **NO** and **Initial**

All **Yes** answers to the following questions must be accompanied by a written statement with dates explaining the circumstances and must be acceptable to the Guam Board of Examiners for Dentistry (GBED).

	YES	NO	INITIAL
1. Has your license or permit to work in a dental office ever been revoked, suspended, or restricted, or has there been any disciplinary action taken against you in any state or territory?	___	___	___
2. Have you been charged, convicted, found guilty of any felony or misdemeanor or been found guilty of a crime, except for minor traffic violations, under the laws of any state. Territory or foreign country?	___	___	___
3. To the best of your knowledge, do you have any communicable (infections) diseases?	___	___	___
4. Has any disciplinary action been taken against you by a government agency, law enforcement agency, any peer review body, health-care institution, or professional dental society regarding your clinical or ethical performance?	___	___	___
5. Have you voluntarily resigned or withdrawn from a national, state, or country dental society, association or organization while under formal or informal investigation by the body?	___	___	___
6. Are you addicted to the use of controlled substances, narcotics, barbiturates, or any other drugs?	___	___	___
7. Are you an alcoholic or do you use alcohol in any habitual manner that could affect your performance in the delivery of dentistry?	___	___	___
8. Do you presently have any physical or mental health condition that could affect your ability to practice the profession of dentistry?	___	___	___

Under penalty of perjury, any misrepresentation to the Guam Board of Examiners for Dentistry can constitute grounds for denial, suspension or revocation of your license or permit. This form, when completed, must be submitted with your application for dental licensure.

Print Name
Signature
Date



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RELEASE OF LIABILITY

In consideration for the evaluation, or re-evaluation of my application, credentials and qualifications for the purpose of licensure or certification in the territory of Guam, I hereby consent to the release of the following information to the Guam Board of Examiners for Dentistry (GBED).

1. Any and all information received from or held by administrators and members of the staff of institutions or dental licensing agencies.
2. Any and all documents held at other institutions that may be pertinent to the evaluation or re-evaluation of my ability or qualifications to provide dental services.
3. Any and all information received from or held by my past and present malpractice insurance carriers with respect to my malpractice claims.
4. Any and all information held by attorneys who have represented me or my insurance carrier in my malpractice claims.

In consideration for the evaluation, or re-evaluation, of my application, credentials and qualifications for the purpose of licensure or certification, I hereby release from liability the Guam Board of Examiners for Dentistry (GBED) who have received information and release from liability all individuals and organizations who may provide information to the GBED, in connection with the evaluation or re-evaluation of my application.

In making application for licensure or certification, I authorize the GBED to verify or request any or all information pertinent to my qualifications or character that it may deem proper.

I agree that a photocopy of this release shall have the same force and effect as the original and may be sent to each individual and institution from whom information is requested.

Print Name

Signature

Date



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CERTIFICATION OF DENTAL EDUCATION

The applicant below is applying for licensure to practice dentistry in the territory of Guam. Please supply the following information and an official copy of the applicant's transcript and return directly to the Guam Board of Examiners for Dentistry at the address: 194 Hernan Cortez Avenue, Terlaje Professional Building, Suite 213, Hagatna, Guam 96910.

TO BE COMPLETED BY THE APPLICANT

Legal Name: _____
Last First Middle

Previous Name Used: _____
Last First Middle

Social Security Number Date of Birth

TO BE COMPLETED BY THE SCHOOL ADMINISTRATOR

Applicant's Name: _____
Last First Middle

Maiden Name/ Other Name: _____
Last First Middle

School of Dentistry

Address

1. Was the Dental School of Graduate training program approved by the ADA at the time of the applicant's enrollment? _____
2. If a foreign Dental school, by what agency was the dental raining program approved?

3. The applicant was enrolled in the training program from _____ to _____.
4. Number of Theory Hours: _____ Number of Clinical Hours: _____
5. Grade Point Average: _____ Class Rank: _____
6. Attached is an Official copy of the applicant's Transcript.

Name of Verifier Title

PLACE FOR OFFICIAL SEAL _____
Signature Date



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RECORD OF PAYMENT

I. IDENTIFICATION:

Name: _____
Last First Middle

Gender: M / F Date of Birth: _____ Place of Birth: _____

Mailing Address: _____

Email Address: _____ Contact No.: _____

Name of Dental Practice/Business: _____

Address: _____

Work Phone: _____ Work Email: _____

Supervising Dentist: _____ Applicant's Signature: _____ Date: _____

II. VERIFICATION OF LICENSURE: Please print the complete name used in original license and your SS number.

Name: _____ Social Security No.: _____

III. FEES: Please make all checks or money orders payable to **TREASURER OF GUAM**. *Online payments* can be made at <https://guamhplo.org/gbed/pay> (additional 5% convenience fee). All fees are **NON-REFUNDABLE**.

Please check your request (s):

DENTIST:

<input type="checkbox"/>	Clinical Examination Fee	\$2,000.00
<input type="checkbox"/>	Dental License NEW Applicant Fee	\$500.00
<input type="checkbox"/>	Dental License RENEWAL Application Fee	\$200.00
<input type="checkbox"/>	Late FEE filing for Dental License renewal application (PER MONTH) after August 31 st	\$200.00
<input type="checkbox"/>	License Verification	\$25.00
<input type="checkbox"/>	Re-Issuance of License Certificate	\$50.00
<input type="checkbox"/>	Copy of Guam Dental Practice Act (https://www.guamcourts.org/CompilerofLaws/GCA/10gca/10gc012.PDF) p.143-163	\$20.00
<input type="checkbox"/>	Copy of GBED Rules and Regulations (https://www.guamcourts.org/CompilerofLaws/GAR/25GAR/25GAR001-8.pdf)	\$20.00
<input type="checkbox"/>	Photocopy (per page)	\$0.50
<input type="checkbox"/>	Specialty License New Application Fee	\$200.00
<input type="checkbox"/>	Specialty License Renewal Application Fee	\$100.00
<input type="checkbox"/>	New Application for Use of Permit for Analgesia, Sedation & General Anesthesia	\$100.00
<input type="checkbox"/>	Renewal for Use of Permit for Analgesia, Sedation & General Anesthesia	\$20.00

HYGIENISTS:

<input type="checkbox"/>	Dental Hygiene License NEW Applicant Fee	\$100.00
<input type="checkbox"/>	Dental Hygiene License RENEWAL Applicant Fee	\$50.00
<input type="checkbox"/>	Late Fee for Dental Hygiene License Renewal after September 30 th	\$50.00
<input type="checkbox"/>	NEW Application for Permit to Administer Local Anesthesia	\$50.00
<input type="checkbox"/>	RENEWAL of Permit to Administer Local Anesthesia	\$50.00

ANCILLARY DENTAL PERSONNEL: Dental Auxiliary Dental Assistant Dental Lab Tech

<input type="checkbox"/>	Dental Ancillary Personnel NEW Registration Fee	\$50.00
<input type="checkbox"/>	Dental Ancillary Personnel RENEWAL Registration Fee	\$30.00
<input type="checkbox"/>	Late FEE for Dental Ancillary Personnel Renewal of Registration after September 30 th	\$50.00

FOR OFFICE USE ONLY: Payment Check Money Order Cash Credit Card

Field Receipt No.: _____ **Date Paid:** _____ **Account No.:** 324156342