

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 Chiropractic (10 GCA, Chapter 12, Article 8 & 11)

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 (Article 11, §121102)

Chiropractic

- ___ 1. Graduation from an accredited Council of Chiropractic Education (CCE) school or college of chiropractic and received a Doctor of Chiropractic ('D.C.') degree.
- ___ 2. Satisfactory completion of at least one (1) year of an internship training program;
- ___ 3. Pass all exams given by the National Board of Chiropractic Examiners (NBCE), Part I, II, III & IV;
- ___ 4. Pass all other exams as required by the Board (GBAHE); **and**
- ___ 5. Possess a current Basic Cardiac Life Support (BCLS) Certification.

Graduate of Foreign School of Chiropractic (Article 11, §121103)

- ___ 1a. Completion of a minimum of three (3) years pre-professional training at an accredited college or University of that foreign country,
- ___ 1b. Fifty percent (50%) of this training must be in basic sciences;
- ___ 2a. Graduation from an accredited school of chiropractic in which it is located.
- ___ 2b. Curriculum at the school of chiropractic must have a minimum period of eight (8) semesters, or the equivalent of not less than four thousand two hundred (4,200) credit hours **provided** that such accrediting agency has a reciprocal agreement with CCE; and
- ___ 3. Pass the National Board of Chiropractic Examiners (NBCE) qualifying exam, Part I, II, III & IV.

**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: 671-735-7407~12**

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" Photo
(Not More than 90 Days Old
& Signed at back).

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:

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

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

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

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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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Marriage & Family Therapist | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Nursing Home Administrator | <input type="checkbox"/> Podiatric Medicine |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Nutritionist/Clinical Dietitian | <input type="checkbox"/> Respiratory Therapy (Certified) |
| <input type="checkbox"/> Clinical Psychology | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Respiratory Therapy (Registered) |
| <input type="checkbox"/> Euthanasia Technician (Certified) | <input type="checkbox"/> Occupational Therapy Assistant | <input type="checkbox"/> Speech Language Asst (Registered) |
| <input type="checkbox"/> Licensed Mental Health Counselor | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Speech Language Pathology |
| <input type="checkbox"/> Licensed Professional Counselor | <input type="checkbox"/> Physical Therapy Assistant | <input type="checkbox"/> 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: _____



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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

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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: 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 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

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(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: _____