GUAM BOARD OF NURSE EXAMINERS
Department of Public Health & Social Services
194 Hernan Cortez Ave, Ste 213
Hagatna, Guam 96910-5052

GUAM NURSING CONTINUING EDUCATION REPORT

Please Type or Print (Use Blue or Black Ink ONLY)

A. IDENTIFICATION: ◯ Mr. ◯ Mrs. ◯ Miss ◯ Ms.

1. Name: _____ Guam Certificate No. _____
   Last First MI
2. Email Address: _____ Telephone No.: _____
3. Current Employer: _____ Position Title: _____

B. CONTINUING NURSING EDUCATION RECORD:
*Do not attach copies of CEU's; if audited, you will be required to submit copies.

DATE	TOPIC	ORGANIZER'S NAME	HOURS
		Total Number of Hours Reports:	

I understand that my application will not be accepted for processing until it has been completed in its entirety and I hereby affirm and declare that the above information is true and correct and that any fraudulent entry may be considered cause for rejection or subsequent revocation. It is also understood that the Guam Board of Nurse Examiners may conduct an audit of the registration activities reported on these forms at anytime.

_____ _____
Signature Date

[ATTACHMENT FORM C]