

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: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> 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 CE's; if audited, you will be required to submit copies.			
DATE	TOPIC	ORGANIZER'S NAME	HOURS
Total Number of Hours Reports:			
<p>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.</p>			
_____		_____	
Signature		Date	