Department of Public Health and Social Services
Health Professional Licensing Office/EMS
Emergency Temporary Work Permit Application

Nursing	**Allied Health**	**Medical**
☐ Advance Practice Registered Nurse ☐ Registered Nurse ☐ Licensed Practical Nurse ☐ Certified Nurse Assistant	☐ Physician Assistant ☐ Respiratory Therapist	☐ Medical Doctor ☐ Doctor of Osteopathy

Last Name:	First Name:	Middle:
Social Security Number:	Email Address:	
Mailing Address:	City:	State & Zip Code:
Home Address:	City:	State & Zip Code:

Home Phone No:	CellPhone:	Other:

Identification:

Date of Birth:	Sex:	Place of Birth:

Other State Licenses: Have you ever been licensed to practice in any other state, territory, province, or Country

State:_____ License #:_____ Issue Date: _____ Expiration Date: _____
State:_____ License #:_____ Issue Date: _____ Expiration Date: _____
State:_____ License #:_____ Issue Date: _____ Expiration Date: _____
State:_____ License #:_____ Issue Date: _____ Expiration Date: _____
State:_____ License #:_____ Issue Date: _____ Expiration Date: _____

Where will you be providing Health Care Services on Guam:

Name of Facility:	Point of Contact:	Contact No:
Email Address: (Point of Contact)		

Signature: _____ Date: _____