



# Guam Board of Allied Health Examiners

Department of Public Health and Social Services  
Health Professional Licensing Office Suite 213  
194 Hernan Cortez Ave. Terlaje Professional Building, Hagatna, Guam 96910-5052

## **GBAHE APPLICATION FOR INITIAL LICENSURE INSTRUCTIONS AND REQUIREMENTS**

**IMPORTANT:** Please adhere to the following instructions carefully to ensure timely processing of your application. Incomplete submissions may result in delays. If additional forms are required, please make copies as necessary. Allow up to 30 days from the submission date before inquiring about the status of your application. Should further information be needed, you will be contacted using the email or phone number provided in your application.

A checklist is included to assist in ensuring your submission is complete. Kindly verify that all required documentation is included and use the checklist to confirm completeness. The Board may request additional documentation to verify or support the information provided. Be sure to retain a copy of all documents submitted for your records.

### **APPLICATION REQUIREMENTS CHECKLIST**

#### **Part A: General Requirements**

##### **Completed Application Form**

- Complete the entire application and submit with original signatures.
- Ensure the application is notarized. 10 GCA § 12824(c).

##### **2x2 Photo**

- Attach a **NEW** 2x2 passport-style photo to page 1 of the application taken within six (6) months of submitting the application.
- Sign **and** date the back of your photo.
- **DO NOT** provide scanned images, Polaroids, or black-and-white photos.

##### **Proof of Identify**

- Provide a copy of your U.S. Passport, Driver's License, Permanent Resident Card, or Work Visa (as applicable).

##### **Record of Payment Form and Fee**

- Complete the entire record of payment form and submit payment of the License Fee. Both fees are non-refundable.
- Make all checks or money order payable to '*Treasurer of Guam*'.
- Online payments may be made on the Board website at <https://guamhplo.org/gbahe/pay>.

##### **Police Clearance**

- If you have lived on Guam for *more* than one (1) year: Submit an original police clearance from the Guam Police Department.
- If you have lived on Guam for *less* than one (1) year: Submit an original police clearance from your most recent places of residence for the five (5) years immediately preceding the date of your application.
- Police clearances must be sent directly to the Board from the issuing agency.

##### **Authorization For Release of Employment Records**

- Complete the entire release of information form. Be sure to carefully read the entire form before signing.

##### **Certificate of Education Form & Official Transcripts**



# Guam Board of Allied Health Examiners

Department of Public Health and Social Services  
Health Professional Licensing Office Suite 213  
194 Hernan Cortez Ave. Terlaje Professional Building, Hagatna, Guam 96910-5052

- Complete Part A of the Certificate of Education Form. Your academic institution must complete Part B of this form and submit the entire form directly to the Board.
- Official transcripts must be sent directly from your academic institution to the Board.

---

## **Endorsement Verification Form**

- Complete Part B and applicable sections of Part C on the Endorsement Verification Form. Your state licensing board must complete Part C and submit the entire form directly to the Board.
- License Verifications must be sent directly from the state licensing board to the Board.

---

## **Three (3) Letters of Recommendation**

- Submit three (3) letters of recommendation from individuals who have known the applicant at least three (3) years. One letter must be from your most recent immediate supervisor, or a practice associate if you're in private practice.
- All letters must be sent directly to the Board from the recommender.

---

## **Verification of Internship Form**

- Complete Part A of the Verification of Internship Form. Your supervisor must complete Part B and submit the entire form directly to the Board.

## **Part B: Requirements Specific to Discipline**

---

### **Requirements Specific to Discipline**

- Please carefully review the specific requirements for your discipline and ensure all listed criteria are submitted in addition to the general requirements.

**Note:** If required items are not submitted with the application, the application will be considered incomplete and will not be processed until all items requested are received.

### **Application Submission Address:**

Guam Board of Allied Health Examiners  
194 Hernan Cortez Avenue  
Terlaje Professional Bldg., Suite 213  
Hagatna, Guam 96910



# Guam Board of Allied Health Examiners

Department of Public Health and Social Services  
Health Professional Licensing Office Suite 213  
194 Hernan Cortez Ave. Terlaje Professional Building, Hagatna, Guam 96910-5052

## ***Requirements for Audiology (10 GCA, Chapter 12, Article 8 and 10)***

### **GENERAL REQUIREMENTS.**

- \_\_\_1. Provide a copy of your U.S. Passport, Driver's License, Permanent Resident Card, or Work Visa (as applicable).
- \_\_\_2. List all jurisdictions in the U.S. or foreign country where you are licensed or have applied for licensure to practice (§12805 (a) (4) (See Application Form);
- \_\_\_3. Document detailed chronological life history, including dates and places of residence (§12805 (a) (8));
- \_\_\_4. Document detailed employment history, including military service in the U.S. or foreign country (§12805 (a) (8));
- \_\_\_5. Document detailed educational history, including places, institutions, dates, and program descriptions (§12805 (a)(7);
- \_\_\_6. All official graduate transcripts must be sent directly to the Board (§12805 (a);
- \_\_\_7. 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;
- \_\_\_8. 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);
- \_\_\_9. A set of fingerprints (paid by the applicant) and a sample of handwriting, *if* requested by the Board; *and*
- \_\_\_10. Any other information or documentation that the Board determines necessary (§12805 (a)(10);
- \_\_\_11. Submit a physical, mental, or professional competency examination or a drug dependency evaluation *if* deemed necessary by the Board.

### **QUALIFICATIONS FOR SPECIFIC DISCIPLINE (Article 10, §121002)**

#### **Audiology**

- \_\_\_1. Possess a 'Certificate of Clinical Competence in Audiology' issued by the American Speech, Language and Hearing Association (ASHA); and
- \_\_\_2. Official statement from ASHA, sent directly to the Board, reporting the applicant's current ASHA certification.



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

194 Hernan Cortez Avenue  
Terlaje Professional Building, Ste. 213  
Hagåtña, GU 96910-5052

## 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: \_\_\_\_\_



# Guam Board of Allied Health Examiners

194 Hernan Cortez Avenue  
Terlaje Professional Building, Ste. 213  
Hagåtña, GU 96910-5052

## 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

194 Hernan Cortez Avenue  
Terlaje Professional Building, Ste. 213  
Hagåtña, GU 96910-5052

## 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

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**.

	<b>Initial Application</b>	<b>Biennial Application</b>
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: \_\_\_\_\_