# 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**

- 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

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***Requirements for Clinical Psychology***
***(10 GCA, Chapter 12, Article 8 and 12)***

## ***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 12, §121202)***

**Clinical Psychology**

___1. A doctorate in clinical psychology from an accredited college or university of the U.S. (§121202 (a);
___2. Completed two (2) years of documented internship*, of which at least one (1) year must be after receiving the doctorate (§121202 (a);
___3. Successfully passed the Examination for Professional Practice in Psychology (EPPP) administered by a state, territory or district of the United States (§121202 (c).

***Applicant must complete the GBAHE-established Clinical Hours FORM**

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***QUALIFICATIONS FOR PRESCRIPTIVE AUTHORITY (§121205) & (§12827)***

An established Collaborative Practice Agreement (CPA) must contain the following:

___1. A detailed list of the scope of practice and list of psychotropic drugs the clinical psychologist is competent to prescribe and may be routinely ordered and prescribed within the scope of practice signed by a collaborating physician;

___2. An alternate physician shall be designated during the absence of the collaborative physician;

___3. The CPA must be approved and signed by the following three (3) boards:

- Board of Allied Health Examiners
- Board of Medical Examiners, and the
- Board of Examiners for Pharmacy

___4. Possess a current Guam Control Substances Registration issued by the Controlled Substances Program, Division of Environmental Health, Department of Public Health and Social Services;

___5. Possess a valid Federal Drug Enforcement Administration (DEA) certificate; and

___6. Proof of completion by a nationally and professionally accepted pharmaceutical curriculum as recognized by the Board;

___7. ***Preferably***, proof of passing a certifying exam in psychopharmacology developed by a nationally recognized institution approved by the Board.

# Guam Board of Allied Health Examiners

**Health Professional Licensing Office**
**Department of Public Health & Social Services**
**194 Hernan Cortez Avenue**
**Terlaje Professional Building, Ste. 213**
**Hagåtña, GUAM 96910**
**Tel: 671-735-7409-12**

## 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:

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

## 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**G. OTHER INFORMATION REQUIRED**: Please check answer. If yes to any question, explain *in detail* separately and attach. For questions 1, 3 through 7, and 10, include copies of the complaint or other charging instrument and the final disposition of the matter.

| | | |
|---|---|---|
| YES | NO | 1) Have you ever been charged, arrested, or convicted of a felony or any other offense involving moral turpitude? |
| YES | NO | 2) Has any state, territory, or foreign country rejected or denied your application for licensure or certification in any profession? |
| YES | NO | 3) Have you ever had a professional license or certificate placed on probationary status, put on restriction, suspended, refused to renew, or revoked by any licensing authority in Guam, or another state, territory, or foreign country? |
| YES | NO | 4) Have you ever been reprimanded, disciplined, or required or asked to surrender a professional license issued by a licensing authority in Guam, another state, territory, or foreign country? |
| YES | NO | 5) Have you ever voluntarily surrendered your license or certificate in any profession in order to avoid disciplinary action by any licensing or regulatory agency in any state, territory, or foreign country? |
| YES | NO | 6) Have you ever been sanctioned or otherwise disciplined by a professional association? |
| YES | NO | 7a) Have you ever been sued for malpractice or other professional liability claim made against you? |
| YES | NO | 7b) Has there been any adverse judgment against you, or settlement by you or made on your behalf as a result of litigation or threatened litigation arising from a professional liability claim against you? |
| YES | NO | 8a) Do you have any medical/physical, mental, or substance-related disorders that may interfere with your ability to competently, Independently, and safely perform the essential functions of your profession? If yes, attach a statement by your primary physician summarizing your limitation. |
| YES | NO | 8b) Are you receiving any ongoing treatment (with or without medication)? |
| YES | NO | 8c) Are you participating in any monitoring program for any of the above? |
| YES | NO | 9) Do you have any outstanding child support, spousal support, alimony or educational loan payment or repayment obligation of 90 days or more in Guam or in any state, territory, or foreign country? *See*, 5 GCA § 34213. |
| YES | NO | a) I am not more than ____ days delinquent in complying with child support order, alimony order or educational loan payment obligations; |
| YES | NO | b) I am more than____ days delinquent in complying with child support order, spousal support order, alimony order or educational loan repayment obligations; |
| YES | NO | c) I am currently under order for child support, spousal support, alimony or educational loan payment obligations. |
| YES | NO | 10) Have you ever been judged incompetent by a court of law? |

**I declare under penalty of perjury that the foregoing information is true to the best of my knowledge and belief. I acknowledge that I am responsible for familiarizing myself with Guam law, including but not limited to Title 10 Guam Code Annotated, Chapter 12, Article 8 and my profession's article, and for notifying the GBAHE within thirty (30) days if any information provided in herein should change.**

_____ DATE: _____

SIGNATURE OF APPLICANT

**TO BE SWORN TO OR AFFIRMED BEFORE AN OFFICIAL AUTHORIZED TO ADMINISTER OATHS**

_____, being duly sworn, says that he or she is the person referred to in the foregoing application and that the statements made therein are true.

Subscribed and Sworn to Before Me this_____ day of_____, 20____.

NOTARY PUBLIC: _____

# 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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**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)*

| | | |
|---|---|---|
| ☐ Acupuncture | ☐ Marriage & Family Therapist | ☐ Physician Assistant |
| ☐ Audiology | ☐ Nursing Home Administrator | ☐ Podiatric Medicine |
| ☐ Chiropractic | ☐ Nutritionist/Clinical Dietitian | ☐ Respiratory Therapy (Certified) |
| ☐ Clinical Psychology | ☐ Occupational Therapy | ☐ Respiratory Therapy (Registered) |
| ☐ Euthanasia Technician (Certified) | ☐ Occupational Therapy Assistant | ☐ Speech Language Asst (Registered) |
| ☐ Licensed Mental Health Counselor | ☐ Physical Therapy | ☐ Speech Language Pathology |
| ☐ Licensed Professional Counselor | ☐ Physical Therapy Assistant | ☐ 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**
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**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: Sate 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 Ave, Terlaje Professional Bldg., Ste. 213**
**Hagåtña, GU 96910-5052**
***(Endorsement Verification cont'd)***

4. Name of School: _____
*(Street or PO Box #)* *(City)* *(State)* *(Zip Code)*
Address: _____
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:_____