



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