GUAM BOARD OF ALLIED HEALTH EXAMINERS
Health Professional Licensing Office

Current Physical Address: **213A Terlaje Bldg., 194 Hernan Cortes Ave. Hagatna, Guam 96910**

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

GENERAL REQUIREMENTS

___ 1. List all jurisdictions in the U.S. or foreign country where licensed or has applied for licensure to practice (§12805 (a) (4)(See Application Form);
___ 2. Document detailed chronological life history, including dates and places of residence (§12805 (a) (8));
___ 3. Document detailed employment history, including military service, in the U.S. or foreign country (§12805 (a) (8));
___ 4. Document detailed educational history, including places, institutions, dates and program descriptions. (§12805 (a)(7));
___ 5. All official graduate transcripts must be ***sent directly to the Board*** (§12805 (a);
___ 6. 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***;
___ 7. 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);
___ 8. A set of fingerprints (paid by the applicant) and a sample of handwriting, ***if*** requested by the Board*; and*
___ 9. Any other information or documentation that the Board determines necessary (§12805 (a)(10)
___10. Submit to 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 an established GBAHE clinical hours FORM**

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 a 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 of 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 Cortes Avenue
213A Terlaje Building
Hagåtña, GUAM 96913
Tel: 671-735-7408

APPLICATION FORM FOR INITIAL LICENSE

General Instructions:

a. Please type or print legibly.

b. Submit a recent (not more than 90 days old) 2" x 2" photograph.

c. Applications for Licensure Form(s) must be notarized. *See*, 10 GCA § 12824(c).

d. Attach a signed Authorization for Release of Employment Records.

e. All FEES paid to the Treasurer of Guam are non-refundable.

1. On-island applicants must pay the applicable fees to the Treasurer of Guam prior to submitting application/renewal form to the Health Professional Licensing Office. Receipt of payment must be attached to this Application Form.

2. Off-Island applicants must pay the applicable fees with a Cashier's check payable to Treasurer of Guam. Attach cashier's check to this completed application and send to HPLO at the address shown above.

f. The Allied Health Practice Act does not provide for the issuance of temporary or conditional licenses.

g. Undergraduate and graduate transcripts, certifications, and verification of licensure by other jurisdictions, are to be sent directly from the educational institution and licensing agency to the Board. Copies of transcripts or licenses delivered by the applicant are not acceptable.

h. Applicants and Licensees are responsible for updating any change in the information provided in their application, in writing, to the Board.

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Health Professional Licensing Office
Department of Public Health & Social Services
194 Hernan Cortes Avenue
213A Terlaje Building
Hagåtña, GUAM 96913
Tel: 671-735-7408

INITIAL LICENSE APPLICATION

Attach Recent 2" X 2" Photo (Not More than 90 Days Old)

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 YES	NO NO	7a) Have you ever been sued for malpractice or other professional liability claim made against you? 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 YES YES	NO NO 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. 8b) Are you receiving any ongoing treatment (with or without medication)? 8c) Are you participating in any monitoring program for any of the above?
YES YES YES YES	NO NO NO 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. a) I am not more than ____ days delinquent in complying with child support order, alimony order or educational loan payment obligations; b) I am more than____ days delinquent in complying with child support order, spousal support order, alimony order or educational loan repayment obligations; 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

123 Chalan Kareta
Mangilao, Guam 96913

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

123 Chalan Kareta
Mangilao, Guam 96913

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.

SIGNATURE: ______________________________

SEAL

NAME: ______________________________

TITLE: ______________________________

DATE: ______________________________

Guam Board of Allied Health Examiners

123 Chalan Kareta
Mangilao, Guam 96913

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

123 Chalan Kareta
Mangilao, Guam 96913
(Endorsement Verification cont'd)

4. Name of School: ____

   Address: ____
   (Street or PO Box #) *(City)* *(State)* *(Zip Code)*

   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

123 Chalan Kareta
Mangilao, Guam 96913

RECORD OF PAYMENT

I. IDENTIFICATION:

LICENSEE NAME: ____
(Last Name) *(First Name)* *(Middle)*

MAILING ADDRESS: ____
(Street or PO Box #)

____
(City) *(State)* *(Zip Code)*

LICENSEE SIGNATURE: ______________________ DATE: ______________

AREA OF PRACTICE *(CHECK ONE)*:

___Acupuncture
___Audiology
___Chiropractic
___Clinical Psychology
___Euthanasia Technician (Certified)
___Licensed Mental Health Counselor
___Licensed Professional Counselor
___Marriage & Family Therapist
___Nursing Home Administrator
___Nutritionist/Clinical Dietitian
___Occupational Therapy
___Occupational Therapy Assistant
___Physical Therapy
___Physical Therapy Assistant
___Physician Assistant
___Podiatric Medicine
___Respiratory Therapy (Certified)
___Respiratory Therapy (Registered)
___Speech Language Asst (Registered)
___Speech Language Pathology
___Veterinary Medicine

II. VERIFICATION OF LICENSURE: If you are requesting verification, please print the complete name used on original Guam License and you Social Security Number.

______________________________ ______________________
Name on Original License Social Security Number

III. FEE: Fees paid are **NON-REFUNDABLE.** Make all checks or money orders payable to **TREASURER OF GUAM.**

1. ( ) Application by Endorsement .... $ 125.00
2. ( ) Application by Examination .... $ 125.00
3. ( ) Nursing Home Administrator Application .... $ 125.00
4. ( ) Certificate of Exemption .... $ 50.00
5. ( ) License Fee (Initial) .... $ 125.00
6. ( ) Renewal Fee .... $ 80.00
7. ( ) Late Renewal Penatly .... $ 100.00
8. ( ) Collaborative Practice Agreement for Prescriptive Authority (Initial or Renewal) .... $ 50.00
9. ( ) License Verification .... $ 25.00
10. ( ) Re-issuance of Certificate .... $ 75.00
11. ( ) Re-issuance of License Card .... $ 10.00
12. ( ) Copy of Practice Act .... $ 5.00
13. ( ) Copy of Rules and Regulations .... $ 10.00
14. ( ) Photocopy of Records (up to five (5) pages) .... $ 4.00
15. ( ) Photocopy of Records (each additional sheet) .... $ 0.50

NOTE: Present this form with payment to the Cashier at Public Health or Treasurer's Office, then return the processed form to GBAHE. Off-island applicants, return this form with your payment (checks or money orders payable to "Treasurer of Guam") to the Guam Board of Allied Health Examiners at the address above.

FOR GUAM BOARD OF ALLIED HEALTH EXAMINERS OFFICE USE ONLY:

PAYMENT TYPE: ( ) Check ( ) Money Order ( ) Cash ( ) Credit Card

FIELD RECEIPT #: ______________________ DATE PAID: ______________