

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 Licensed Professional Counselor (LPC),
Licensed Mental Health Counselor (LMHC), and Marriage & Family Therapist (MFT)
(10 GCA, Chapter 12, Article 8 and Public Law 32-054)***

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

Licensed Professional Counselor (LPC)

- ___ 1. A doctorate or master's degree from an accredited school in the U.S. or Territory.
 - 2.
- ___ 2a. A minimum of three thousand (3,000) hours of *documented** client service, of post- graduate experience under the supervision of a LPC, Clinical Psychologist or Psychiatrist.
or
- ___ 2b. If an applicant cannot document two (2) years of post-graduate supervised experience, he/she may submit proof of having worked under an internship program that provided the two (2) years of post-graduate experience, approved by the Board.

REQUIREMENT OF 3,000 CLINICAL HOURS*

- 1. Face to face contact of hours with
 - a) Individual,
 - b) Couple, and
 - c) Family;
- 2. Direct supervision (minimum of hours required); and
- 3. Case conference (minimum of hours required).

*Applicant must complete the GBAHE established Clinical Hours FORM

Licensed Mental Health Counselor

1. A doctoral or Master's Degree from an accredited school in the U.S. or Territory;
2. Pass the National Clinical Mental Health Counselor Examination (NCMHCE);
3. Document evidence of one thousand (1,000) hours of post Masters clinical work in diagnostic and treatment planning.

Marriage and Family Therapist

1. A doctoral or Master's Degree from an accredited school in the U.S. or Territory.
2. Pass the National Clinical Mental Health Counselor Examination (NCMHCE).
- 3.

QUALIFICATIONS FOR INTERN LICENSE

1. Mental Health Counselor Intern License

2. Marriage and Family Therapist Intern License

**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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Department of Public Health & Social Services
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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:

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

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.

SIGNATURE OF APPLICANT

DATE: _____

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
Health Professional Licensing Office
Room 213A Terlaje Bldg., 194 Hernan Cortes Ave., Hagatna, GUAM 96910

APPLICATION TO SIT FOR

- ___ National Board for Certified Counselors (NBCC) for *Licensed Professional Counselor (LPC)*
___ National Mental Health Clinical Counselor Exam for *Licensed Mental Health Counselor (LMHC)*
___ Marriage & Family Therapist specialist exam for *Marriage & Family Therapist (MFT)*

GENERAL INFORMATION:

The Guam Board of Allied Health Examiners has the sole authority to determine a Candidate's eligibility to take the examination(s).

Recent Photo 2x2
Less than 90 days

A. IDENTIFICATION:

1. NAME: _____
Last First Middle Maiden

2. SOCIAL SECURITY NUMBER: _____ 3. SEX: _____

4. DATE OF BIRTH: _____ 5. PLACE OF BIRTH: _____
City State

6. PERMANENT ADDRESS: _____

7. MAILING ADDRESS: _____

8. TELEPHONE: _____ 9. Email: _____
Work Cell Home

B. POST GRADUATE/ DOCTORAL INFORMATION:

Please provide a copy of Graduate School Transcript for verification (a requirement)

College/University: _____

Address: _____

Date Graduated: _____ Degree received: _____

(Signature of Applicant)

(Date)

C. Approved by Board Member:

(NAME)

(SIGNATURE)

(DATE)

D. ID # Assigned: _____ (for Examination Purpose)



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)

- | | | |
|--|--|--|
| <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

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 NAMED 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

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):

- | | | |
|--|--|--|
| <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 |

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 Penalty | \$ 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: | _____ |