

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 Physical Therapy (10 GCA, Chapter 12, Article 8 & 15)

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 transcripts, undergraduate or graduate, 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 15 §121502)

Physical Therapy (PT)

- ___ 1. Bachelor's Degree or *certificate* in Physical Therapy (PT) from an accredited school of physical therapy in the United States;
- ___ 2. Successful completion of a four (4) year degree program, or a two (2) year certificate program, or advanced program including supervised clinical experience; and
- ___ 3. Successful passed an examination administered by the Professional Examination Service (PES) in the U.S., or passes an examination administered by PES in one of its territories and have been granted a license.
- ___ 4. Supervision of supportive personnel (§ 121505)
A PT is professional and legally responsible for the patient care given by supportive personnel under his/her supervision.

Foreign Graduates (§ 121506)

- ___ 1. Diploma from an educational program for PT approved by the Board that must contain courses in humanities, social sciences, biology and other physical sciences;

- ___ 2. Applicant's credentials must be equivalent to a U.S. degree in Physical Therapy. Applicant's academic records must be evaluated by either the International Education Research Foundation (IERF) or the International Consultants of Delaware (ICD). If educational background is *not* equivalent to a U.S. accredited PT program, or the applicant's program is found deficient in PT credits, the applicant must successfully complete a PT program which conforms with the standards of the official accrediting agency determined by the U.S. Office of Education, or at the discretion of the Board, complete specific courses in PT;
- ___ 3. Complete a minimum of twenty (20) continuous weeks of *documented* internship under direction of and immediate supervision of a physical therapist, in an institution approved by the Board;
- ___ 4. Pass an examination in PT given by a state or territory within the United States;
- ___ 5. Letter from the most recent employer verifying the applicant's position and dates of employment.

PHYSICAL THERAPY ASSISTANT (§121502(b))

- ___ 1. Minimum of an associate's degree from an approved school for physical therapy assistant (PTA) in the U.S. ;
- ___ 2. Successful completion of a two (2) year degree program;
- ___ 3. Proof of supervised clinical experience; and
- ___ 4. *PTA* works under the indirect supervision of a PT.

Foreign Graduates (§ 121506)

- ___ 1. Proof of a diploma from an educational program for PTA approved by the Board that must contain courses in humanities, social sciences, biology and other physical sciences;
- ___ 2. Associate's degree from an approved school for physical therapy assistant (PTA) equivalent to a U.S. degree in PTA. Applicant's academic records must be evaluated by either the International Education Research Foundation (IERF) or the International Consultants of Delaware (ICD);
- ___ 3. Successful completion of a two (2) year degree program which must include supervised clinical experience;
- ___ 4. Pass an examination given by the Professional Examination Service in the United States or one of its territories;
- ___ 5. Had been granted a current PTA license; and
- ___ 6. Letter from most recent employer verifying the applicant's position and dates of employment.

**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.

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

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

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)

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

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

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, ANSWERS 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):

- | | | |
|--|--|--|
| <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:	_____