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 Physician Assistant (10 GCA, Chapter 12, Article 8 & 16)

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*
___ 10. Any other information or documentation that the Board determines necessary (§12805 (a)(10)
___ 10a. 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 16* §121602)**

Physician Assistant

___ 1. Graduation of an accredited Committee on Allied Health Education and Accreditation (CAHEA) Institution;
___ 2. Successfully passed a proficiency examination for certification developed by the National Commission on Certification of Physician Assistants (NCCPA);
___ 3. PA must be under the supervision of a registered, supervised physician (**§ 121607)**.

***Prescriptive Authority (*§ 12827)**
___ 1. Collaborative Practice Agreement (CPA) approved by the following three (3) boards:
   a. Guam Board of Allied Health Examiners,
   b. Guam Board of Medical Examiners, and
   c. Guam Board of Examiners for Pharmacy;

___ 2. Collaborative Practice Agreement (CPA), must be renewed upon licensure renewal, includes
   ___ a. Scope of practice;
   ___ b. List of drugs that may be routinely ordered and prescribed.
   ___ c. Other than Scheduled II – III, the physician assistant (PA) may administer, prescribe and

dispense (Title 25 GAR Professional and Vocational Regulations, Chapter 10, § 10109), any licensed drug under the delegated authority of the supervised physician at all times;

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

___ e. Possess a valid Federal Drug Enforcement Administration (DEA) certificate.

___ f. A new CPA must be submitted for approval by the three (3) boards once the primary and/or alternate physicians are no longer supervising the PA.

___ g. 1. The PA must notify the Board at least ten (10) days prior to the effective date of a new CPA.
2. Complete CPA Form and submit to the Guam Board of Allied Health Examiners (GBAHE) for review and approval.
3. It is the responsibility of the PA to submit the approved CPA to CSP for registration.

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:

- ☐ 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

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.

SEAL

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: 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

APPLICATION TO SUPERVISE A PHYSICIAN ASSISTANT

GENERAL INFORMATION

1. Name of Physician: _____
   (Last Name) (First Name) (Middle)
2. Mailing Address: _____
   (Street or PO Box #) (City) (State) (Zip Code)
3. Phone Number: _____ _____ 4. Guam Medical License Number: _____
   (Office) (Message)
4. Indicate Residency Training Completed: _____
   (Where) (Specialty) (Date)
5. Have you ever applied for approval to supervise a Physician Assistant? Yes ☐ No ☐
   If answer is "Yes", give name(s), type(s), date(s), location(s) and details._____
   _____
   _____
6. Is this application being submitted in conjunction with another physician's application to supervise said Physician Assistant?
   Yes ☐ No ☐
   If "Yes", list names of other physicians who will supervise the same Physician Assistant: _____
   _____
   _____
7. Who will be your Physician Assistant? _____

GENERAL INFORMATION

1. Type (e.g., Family, Industrial, etc.) and Specialty: _____
   If Family Practice, indicate percentage of time spent in the following:
   Surgery _____ Medicine _____ OB/GYN _____ Pediatrics _____ Other _____
2. Are you Board Certified? Yes ☐ No ☐ Date of Certification _____
   Indicate which Board specialty _____ Are you Board Eligible? Yes ☐ No ☐
3. Indicate: Solo Practice _____ Group Practice _____ Number in Group _____
4. Name of Group _____ Single-Specialty _____ Multi-Specialty _____
5. Have you ever had your hospital staff privileges denied, suspended, revoked? Yes ☐ No ☐
   If yes, explain: _____
   _____
6. Have you ever had any medical license suspended, revoked, or otherwise disciplined? Yes ☐ No ☐
   If yes, explain: _____
   _____

USE AND NEEDS PROJECTIONS

1. Describe fully how you propose to utilize a Physician Assistant, i.e., duties to be performed by the Physician Assistant.
   _____
   _____
2. Protocols and specific plans for supervision of the Physician Assistant, i.e., frequency of the chart review, availability for immediate in-person consultation, situations beyond ability and scope of Physician Assistant.
   _____
   _____
3. Protocol for patients examined by a Physician Assistant and who require prescription medicine. _____
   _____
   _____
4. Type of health care facility in which the Physician Assistant will be functioning _____
   _____
5. Physician's relationship to facility(ies) _____
   _____

I have read and fully understand the Physician Assistant Regulations promulgated by the Guam Board of Allied Health Examiners and apply for approval to supervise a Physician Assistant in the Territory of Guam in accordance with those laws and state under penalty of perjury under the laws of the Territory of Guam that I am the person whose signature is affixed below and that all statements made are true in every respect, and understand that mis-statements or omissions of material facts may be cause for denial of this application or revocation of any approval granted.

_____ _____
Signature of Physician Date

All information is mandatory. Failure to provide any of the mandatory information will result in the application being rejected as incomplete. Each individual has the right to review his/her file maintained by the agency, subject to the provisions of the Information Practices Act.

Guam Board of Allied Health Examiners

123 Chalan Kareta
Mangilao, Guam 96913

SUPERVISING PHYSICIAN FORM

FOR

PHYSICIAN ASSISTANT

Physician Assistant's Name: _____

Physician Assistant's Address: _____
(Street or PO Box #)

_____
(City) *(State)* *(Zip Code)*

Supervising Physician	Specialty	Signature

Statement from Supervising Physician specifying specialty areas in which the Physician Assistant should provide services:

_____

_____

_____

_____

_____

_____

_____

Guam Board of Allied Health Examiners

123 Chalan Kareta
Mangilao, Guam 96913

Collaborative Practice Agreement for Physician Assistants

The Physician Assistant (PA) will only prescribe medicines outlined in the list below under the supervision of his or her Supervising Physician. The Supervising Physician and the PA will determine the appropriate medications to be prescribed under his or her scope of practice and submit the CPA to the Guam Board of Allied Health Examiners (GBAHE), the Guam Board of Medical Examiners (GBME), and the Guam Board of Examiners for Pharmacy (GBEP).

A copy of the CPA will be files at the Health Professional Licensing Office (HPLO) in the files of the GBAHE, GBME, GBEP, and the Physician Assistant.

The PA may prescribe from those categories checked in the following list:

A. Drugs			Exceptions applicable to each category
_____	01	Anesthetics	_____
_____	02	Anti-infective	_____
_____	03	Anti-neoplastics/Immunosuppresants	_____
_____	04	Cardiovascular Medications	_____
_____	05	Autonomic/CNS Drugs	_____
_____	06	Dermatologic Drugs	_____
_____	07	Diagnostic Agents	_____
_____	08	Ear-Nose-Throat Medications	_____
_____	09	Endocrine Medications	_____
_____	10	Gastrointestinal Medications	_____
_____	11	Immunologicals and Vaccines	_____
_____	12	Muskuloskeletal Medications	_____
_____	13	Nutritional Products, Electrolytes and Blood Modifiers	_____
_____	14	OB/GYN Medications	_____
_____	15	Opthalmin Medications	_____
_____	16	Respiratory Medications	_____
_____	17	Urological Medications	_____
_____	18	Poisoning and Drug Dependence	_____
_____	19	Analgesics	_____
_____	20	Stimulants	_____
_____	21	Tranquillizers	_____

B. Controlled Substances

Schedule II _____ Schedule IV _____
Schedule III _____ Schedule V _____

Identification:

Physician Assistant (Print Name): Signature DEA Certificate Number

_____ _____ _____

Supervising Physician (Print Name): Signature DEA Certificate Number

_____ _____ _____

PRACTICE SITES:

Name of Primary Practice Site on Guam: Practice Setting:

_____ _____

Location Address: _____
(Street) (City) (State) (Zipcode)

Name of Other Practice Site on Guam Practice Setting:

_____ _____

Location Address: _____
(Street) (City) (State) (Zipcode)

Guam Board of Allied Health Examiners

123 Chalan Kareta
Mangilao, Guam 96913

Collaborative Practice Agreement for

Physician Assistants

I, _____, Physician Assistant and _____, MD/DO, the Supervising Physician agree to the following scope of practice:

1)

2)

3)

4)

5)

6)

7)

8)

9)

10)

11)

_____ _____

Signature of Physician Assistant Signature of Supervising Physician

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	☐ 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

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: _____