Guam Board of Allied Health Examiners

Department of Public Health & Social Services

Health Professional Licensing Office

194 Hernan Cortez Avenue, Terlaje Professional Building Suite 213, Hagåtña, GUAM 96910
Tel: 671-735-7409

LICENSE RENEWAL
General Instructions

I. Please type or **print** legibly. Be sure and complete and attach a completed Continuing Education Report form with supporting documentation. Illegible and incomplete submissions will not be considered.

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

   A. 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.

   B. 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 renewal application and send to HPLO at the address shown above.

III. All licenses expire biennially on the 31st of December of each even numbered year. Title 10 GCA § 12813, provides, "Any person who practices a healing art profession without an appropriate current valid license, as regulated by this Board, shall be guilty of a misdemeanor upon the first offense and guilty of a felony for second and subsequent offenses." Therefore, it is strongly encouraged that renewal applications and proof of required Continuing Education Units be submitted to the HPLO as soon as possible in order to give the Board ample time for review.

IV. Licensees are responsible for notifying the Board immediately and in writing of any change in address, name, or other information contained in this Form.

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LICENSE RENEWAL FORM

A. Date of Renewal:___________________

B. License No.: ______________________

C. IDENTIFICATION:

NAME: ____
Last First Middle (Maiden)

OTHER NAMES / ALIASES________________________________

Sex: M ☐ F ☐ Date of Birth:__________________SOCIAL SECURITY #:______________________

PHYSICAL ADDRESS: ____________________________________

MAILING ADDRESS: ____________________________________

CURRENT PRACTICE / CLINIC ADDRESS: ______________________

(Any change of office/clinic/practice address must be reported promptly to the Board)

EMAIL ADDRESS:____

WORK PHONE:______________________HOME PHONE:________________________CELL PHONE:____________________

D. Discipline for Which You Are Seeking License Renewal:

___Acupuncturist
___Audiologist
___Chiropractor
___Clinical Psychologist
___Nursing Home Administrator
___Licensed Mental Health Counselor
___Licensed Professional Counselor
___Marriage & Family Therapist
___Clinical Dietitian/Nutritionist
___Occupational Therapist
___Occupational Therapist Assistant
___Physical Therapist
___Physical Therapist Assistant
___Podiatrist Medicine
___Physician Assistant
_____Respiratory Therapist (Reg.)
_____Respiratory Therapist (Cert.)
_____Respiratory Therapy (Tech)
____Speech Language Pathologist
____Speech Lang. Path. Asst. (Bachelor's Level)
____Speech Lang. Path. Asst. (Master's Level)
____Veterinary Medicine

E. COMPLETE AND ATTACH THE CONTINUING EDUCATION REPORT FORM. BE SURE TO INCLUDE CERTIFICATE OF COMPLETION OR OTHER PROOF OF ATTENDANCE.

F. PROFESSIONAL LICENSES:

List all professional 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

G. OTHER INFORMATION REQUIRED: Please circle answer. If you answer yes to any question, explain *in detail* separately and attach. For questions1, 3 through 7, and 9, include copies of the complaint or other charging instrument and the final disposition of the matter. This section is limited to the time since your most recent application or renewal.

YES		NO		Question
YES		NO		1) Have you 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 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 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 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 been sanctioned or otherwise disciplined by a professional association?
YES		NO		7a) Have you 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 your 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) Have you been judged incompetent by a court of law?

6GCA Division 2 Chapter 4 Section 4308 Unsworn Declaration Under Penalty of Perjury.

(1) If executed outside of Guam: "I declare (or certify, verify or state) under penalty of perjury under the laws of Guam that the foregoing is true and correct. Executed on ____________________________________
(date)

____________________________________."
(Signature)

(2) If executed within Guam, or within a state having a rule of law or procedure similar in effect to this Section: "I declare (or certify, verify or state) under penalty of perjury that the foregoing is true and correct. Executed on________________________ ____________________________________."
(date) (Signature)

Subscribed and Sworn to Before Me this_____ day of_________________________, 20____.

NOTARY PUBLIC: ______________________________________

AFFIX SEAL HERE

Revised: 09/15/22

BOARD OF ALLIED HEALTH EXAMINERS

194 Hernan Cortez Ave., Suite 213 Terlaje Bldg., Hagåtña, Guam 96910

CONTINUING EDUCATION REPORTING FORM

(A Provided by 10 GCA CHAPTER 12 DIVISION 1, PART 1, ARTICLE 8, § 12809)

The following REQUIREMENTS must be completed within the two (2) year licensure period. Continuing Education (CE) *hour* means *contact hour.* ***Licensee MUST attach documents demonstrating proof of hours claimed.***

- **A)** **For the following disciplines – Thirty (30) CONTACT HOURS** of which twenty (20) contact hours must be in the licensee's specific area of practice): Acupuncture, Audiology, Chiropractic, Clinical Psychology, Occupational Therapy, Physical Therapy, Respiratory Therapy, Speech Language Pathology, Veterinary Medicine, Clinical Dietician / Nutritionist, Nursing Home Administrator.
- **B)** For Licensed Professional Counselor – **Forty (40) CONTACT HOURS "*directly related to the practice of Professional Counseling*"**
- **C)** For Licensed Mental Health Counselor – **Forty (40) CONTACT HOURS "*directly related to the practice of Mental Health Counseling*"**
- **D)** For Marriage & Family Therapist – **Forty (40) CONTACT HOURS "*directly related to the practice of Marriage & Family Therapy*"**
- **E)** For Physician Assistant and Podiatry – **Fifty (50) CONTACT HOURS**
- **F)** For prescribing Clinical Psychologist – **Twenty (20) additional contact hours in *psychopharmacology or psycho-pharmacotherapy*.**
- **G)** **Other Requirement(s):** 1) For Chiropractors, current and valid BCLS; 2) for Podiatrist, current and valid certificate in basic CPR.

ACCEPTABLE CONTINUING EDUCATION	DATE(S)	NAME OR TITLE VENUE /ADDRESS	CE HRS
MEMBERSHIP IN NATIONAL ASSOCIATIONS: IN THE LICENSEE'S PRACTICE AREA. Show proof of current membership validated by letter or membership card. Four (4) CE hours within the renewal period. Maximum of four (4) CE hours. OTHER APPROPRIATE NATIONAL PROFESSIONAL ASSOCIATION MEMBERSHIP: Two (2) CE hours within the renewal period. Maximum of four (4) CE hours.			
SUBSCRIPTION TO APPROPRIATE PROFESSIONAL JOURNALS: Show proof of subscription in Licensee's name and address. Journal or Newsletter that is included in an association's membership is not counted. Two (2) CE hours per subscription within the renewal period. Limited to five (5) subscriptions or ten (10) CE hours.			
CONFERENCES ATTENDED WITHIN THE RENEWAL PERIOD: Sponsored by local, national, international recognized professional association/institution. One (1) CE hours for each contact hour NO LIMIT. Show proof of attendance (certificate, letter issued by sponsor indicating the number of hours.			
TEACHING, WORKSHOP, IN-SERVICE TRAINING: The licensee is the teacher/instructor providing the teaching, conducting the workshop or training. Submit course syllabus or agenda showing the licensee's name, date, time, venue and sponsor. One (1) CE hour per hour of teaching within the renewal period. Limited to ten (10) CE hours.			

ACCEPTABLE CONTINUING EDUCATION	DATE(S)	NAME OR TITLE VENUE / ADDRESS	CE HRS
SPEECHES OR PRESENTATION OF PAPERS: Submit title of speech or presentation showing the licensee's name, date, time venue, and sponsor. Ten (10) CE hours each for LICENSED PROFESSIONAL AUDIENCE. Five (5) CE hours each for NON-PROFESSIONAL AUDIENCE.			
PUBLICATION IN PROFESSIONAL JOURNALS: Ten (10) CE hours for any publication within the field of practice. Show proof of publication in Licensee's name.			
LOCAL ASSOCIATION MEETINGS: Submit proof or certificate of attendance. One (1) CE hour per meeting. Limited to twelve (12) CE hours within the renewal period.			
AUDIO-VISUAL MATERIALS/ WEBINARS WITHIN THE LICENSEE'S FIELD OF PRACTICE: Produced by a national or international professional association or recognized educational institution: A) One (1) CE hour for every hour viewed or listened to without tests; limited to ten (10) CE hrs. B) One (1) CE hour for every hour viewed or listened to with required test, no limit of CE hours claimed. C) Non national association presentation must be approved by the Board prior to claiming CE hours Must provide proof of Certificate of Completion indicating the number of credit hours earned.			

TOTAL CE HOURS CLAIMED = _______________
Attach documents

For Chiropractor: Current BCLS expires on_____________________(**date**)
For Podiatrist: Current CPR expires on date_____________________(**date**)

I declare under penalty of perjury that the foregoing continuing education hours claimed is true.

____ DATE:_______________
LICENSEE SIGNATURE

PROFESSION:____

************************************ **For Official Use Only** **************************************

Renewal Fee Paid: $__________Date Rec'd:________Late Renewal Fee: $__________Date Rec'd: _________
Reviewed by HPLO Staff:________Date:__________Reviewed by Board Member:__________Date:__________
(Initial) (Initial)

Revised: 09/15/22

Guam Board of Allied Health Examiners

194 Hernan Cortez Avenue
Terlaje Professional Building, Suite 213
Hagåtña, Guam 96910-5052

RECORD OF PAYMENT

I. IDENTIFICATION:

Name:____
(Last Name) (First Name) (M.I.)

II. VERIFICATION OF LICENSURE: If you are requesting verification, please print your complete name used on your original Guam License.

Name on Original License:____

License #:____________________ Signature:______________________________ Date:__________________

III. FEE: Fees paid are **NON-REFUNDABLE**. Make check or money order payable to **TREASURER OF GUAM**.

		Initial Application	Biennial Application
1.	Acupuncture and Oriental Medicine	$350	$250
2.	Audiology	$250	$200
3.	Chiropractic	$350	$250
4.	Clinical Psychology	$350	$250
5.	Psychology Associate	$200	$150
6.	Licensed Professional Counselor	$250	$200
7.	Licensed Professional Counselor Intern	$200	$150
8.	Licensed Mental Health Counselor	$300	$250
9.	Licensed Mental Health Counselor Intern	$200	$150
10.	Marriage and Family Therapist	$300	$250
11.	Marriage and Family Therapist Intern	$200	$150
12.	Occupational Therapist	$250	$200
13.	Occupational Therapist Assistant	$200	$100
14.	Physical Therapy	$300	$250
15.	Physical Therapy Assistant	$200	$100
16.	Speech-Language Pathologist	$300	$250
17.	Speech-Language Assistant	$200	$150
18.	Respiratory Therapist	$250	$200
19.	Certified Respiratory Therapist	$200	$100
20.	Veterinary Medicine	$350	$250
21.	Nursing Home Administrator	$250	$200
22.	Nutritionist	$300	$250
23.	Clinical Dietician	$200	$100
24.	Euthanasia Technician (Annual)	$150	$100
25.	Examinations When Required by Law or Rule	$250	$250
26.	Application for Prescriptive Authority	$250	$250
27.	Late Renewal Penalty (Up to One Year)		$100
28.	Late Renewal Penalty (One Year and a Day to Two Years)		$200
29.	Late Renewal Penalty (Two Years and a Day to Three Years)		$300
30.	Late Renewal Penalty (Three Years and a Day to Four Years)		$400
31.	Name Change Certificate Request		$100
32.	Replacement (Lost) Identification Card		$100
33.	Reinstatement of Suspended License		$300
34.	Petition for Reinstatement of Expired License		$500
35.	Petition for Reinstatement of Revoked License		$500
36.	Verification of Guam License (Certificate of Good Standing)		$50
37.	Inactive License		one-half (1/2) the renewal fee
38.	Returned Check Fee		$40
39.	Other (Balance)		$_______

NOTE: Please make a copy for Treasurer of Guam and return this original Form to HPLO/GBAHE with your receipt of payment. For off-island Applicants or Licensees, please enclose this form with your application and make check or money order payable to "Treasurer of Guam".

FOR GUAM BOARD OF ALLIED HEALTH EXAMINERS OFFICE USE ONLY:

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

FIELD RECEIPT #:______________________________________ DATE PAID:____________________