



# Guam Board of Allied Health Examiners

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

September 9, 2022

Dear Licensee:

All licenses issued by the Guam Board of Allied Health Examiners (GBAHE) expire biennially on December 31<sup>st</sup> of each even numbered year. Your current license expires on December 31, 2022.

According to the **Guam Allied Health Practice Act, 10 Guam Code Annotated, Chapter 12, Division 11, Part 1, Article 8-21, Section 12824. Renewal of licensure.** The Licensee is required "(a) At the time of renewal of licensure, the Board shall require the licensee to demonstrate their continuing qualification for licensure." You are required to report any adverse action taken against you by any jurisdiction or authority.

You are required to sign the renewal application form for license re-registration and have it **notarized (Section 12824 (c))**.

For this renewal cycle only, there is no limit to CE/CEU hours for Live Virtual Courses, Webinars, and Online Education from a recognized local, National or International organization.

For CE hours or CEU to be claimed, please submit a copy of attendance certificate or letter of verification indicating your name: a) Conferences attended, Live Virtual Courses, Webinars, or Online Education from RECOGNIZED local, national, and international organizations; b) Teaching Workshop or In-Service Training (you were the teacher), In-Service Training (you were the participant); c) Lecture or Presentation of Papers (submit a copy of the Speech and/or Paper).

In complying with the Allied Health Practice Act, you are also responsible for:

- 1) Informing the Board of any change in name (certified copy of the evidence), mailing and practice addresses, and email address.
- 2) Notify the Board, in writing, of the loss of your current license.
- 3) Keeping a signed current license in your possession.
- 4) Conspicuously display your license in office(s) or clinic where you regularly practice.
- 5) Per Public Law 35-49, a licensee "(b) is responsible for being familiar with and following the Code of Ethics of your individual profession."
- 6) Licensee found practicing after the expired date is deemed in violation of the Allied Health Practice Act (§ 12813).

The Board encourages you to submit your Renewal Application as soon as possible. If you should have any questions, contact Ms. Rosemary Carman at [rosemary.carman@dphss.guam.gov](mailto:rosemary.carman@dphss.guam.gov). Also, please refer to Guam Compiler of Laws, Guam Code Annotated, Title 10 Health and Safety, Division 1 Public Health, Chapter 12 Medical Practices, Article 8.

Sincerely,

**MAMIE C. BALAJADIA, Ed.D.**

Chair, Guam Board of Allied Health Examiners

Attachments: Renewal Application

# **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 31<sup>st</sup> 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.



**G. OTHER INFORMATION REQUIRED:** Please circle answer. If you answer yes to any question, explain *in detail* separately and attach. For questions 1, 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	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 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) 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**

## 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
<p><b>MEMBERSHIP IN NATIONAL ASSOCIATIONS:</b></p> <p>IN THE LICENSEE’S PRACTICE AREA. <u>Show proof</u> of current membership validated by letter or membership card. Four (4) CE hours within the renewal period. Maximum of four (4) CE hours.</p> <p>OTHER APPROPRIATE NATIONAL PROFESSIONAL ASSOCIATION MEMBERSHIP: Two (2) CE hours within the renewal period. Maximum of four (4) CE hours.</p>			
<p><b>SUBSCRIPTION TO APPROPRIATE PROFESSIONAL JOURNALS:</b></p> <p><u>Show proof</u> 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.</p>			
<p><b>CONFERENCES ATTENDED WITHIN THE RENEWAL PERIOD:</b></p> <p>Sponsored by local, national, international recognized professional association/institution. One (1) CE hours for each contact hour NO LIMIT. <u>Show proof</u> of attendance (certificate, letter issued by sponsor indicating the number of hours.</p>			
<p><b>TEACHING, WORKSHOP, IN-SERVICE TRAINING:</b></p> <p>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.</p>			





# Guam Board of Allied Health Examiners

Mailing and Physical Address: Suite 213 Terlaje Bldg.  
194 Hernan Cortez Ave., Hagatna, Guam 96910

## RECORD OF PAYMENT

I. LICENSEE NAME: \_\_\_\_\_  
(Last Name) (First Name) (Middle)

MAILING ADDRESS: \_\_\_\_\_  
(Street or PO Box #)

\_\_\_\_\_  
(City) (State) (Zip Code)

LICENSEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### II. PROFESSION (CHECK ONE):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Acupuncturist                    | <input type="checkbox"/> Nursing Home Administrator       | <input type="checkbox"/> Respiratory Therapist, Certified         |
| <input type="checkbox"/> Audiologist                      | <input type="checkbox"/> Nutritionist/Clinical Dietitian  | <input type="checkbox"/> Respiratory Therapist, Registered        |
| <input type="checkbox"/> Chiropractor                     | <input type="checkbox"/> Occupational Therapist           | <input type="checkbox"/> Respiratory Therapist, Technician        |
| <input type="checkbox"/> Clinical Psychologist            | <input type="checkbox"/> Occupational Therapist Assistant | <input type="checkbox"/> Speech Language Pathologist              |
| <input type="checkbox"/> Nursing Home Administrator       | <input type="checkbox"/> Physical Therapist               | <input type="checkbox"/> Speech Language Asst. (Bachelor's Level) |
| <input type="checkbox"/> Licensed Mental Health Counselor | <input type="checkbox"/> Physical Therapist Assistant     | <input type="checkbox"/> Speech Language Asst. (Master's Level)   |
| <input type="checkbox"/> Licensed Professional Counselor  | <input type="checkbox"/> Physician Assistant              | <input type="checkbox"/> Veterinary Medicine                      |
| <input type="checkbox"/> Marriage & Family Therapist      | <input type="checkbox"/> Podiatrist Medicine              |   |

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

\_\_\_\_\_  
Name on Original License Social Security Number

### IV. 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 the Treasurer's Office in the GITC Bldg., 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: \_\_\_\_\_



# Guam Board of Allied Health Examiners

Mailing and Physical Address: Suite 213 Terlaje Bldg.  
194 Hernan Cortez Ave., Hagatna, Guam 96910

## RECORD OF PAYMENT **CASHIER'S COPY**

I. LICENSEE NAME: \_\_\_\_\_  
(Last Name) (First Name) (Middle)

LICENSEE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

### II. PROFESSION (CHECK ONE):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Acupuncturist                    | <input type="checkbox"/> Nursing Home Administrator       | <input type="checkbox"/> Respiratory Therapist, Certified         |
| <input type="checkbox"/> Audiologist                      | <input type="checkbox"/> Nutritionist/Clinical Dietitian  | <input type="checkbox"/> Respiratory Therapist, Registered        |
| <input type="checkbox"/> Chiropractor                     | <input type="checkbox"/> Occupational Therapist           | <input type="checkbox"/> Respiratory Therapist, Technician        |
| <input type="checkbox"/> Clinical Psychologist            | <input type="checkbox"/> Occupational Therapist Assistant | <input type="checkbox"/> Speech Language Pathologist              |
| <input type="checkbox"/> Nursing Home Administrator       | <input type="checkbox"/> Physical Therapist               | <input type="checkbox"/> Speech Language Asst. (Bachelor's Level) |
| <input type="checkbox"/> Licensed Mental Health Counselor | <input type="checkbox"/> Physical Therapist Assistant     | <input type="checkbox"/> Speech Language Asst. (Master's Level)   |
| <input type="checkbox"/> Licensed Professional Counselor  | <input type="checkbox"/> Physician Assistant              | <input type="checkbox"/> Veterinary Medicine                      |
| <input type="checkbox"/> Marriage & Family Therapist      | <input type="checkbox"/> Podiatrist Medicine              |   |

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

_____	_____
Name on Original License	Social Security Number

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

- |   |           |
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| 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   |

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**FOR GUAM BOARD OF ALLIED HEALTH EXAMINERS OFFICE USE ONLY:**

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

FIELD RECEIPT #: \_\_\_\_\_ DATE PAID: \_\_\_\_\_