DPBDUGRIOOLHGHDOWKPLQHUV
HDOWKURIHVVRQDOLFHQVLQ2IILFHHSDUWPHQWRI3XEOLFHDOWKRFLDO6HUYLFHV
HUQDQ&RUWHV]HQH6WH7HUODMH\OGLQJDWxD0

Tel: 671-735-7407 thru 10

LICENSE RENEWAL FORM

[ ] I am a a m a a [ ] I am NOT a a a

$ **License No.:** ______________________

Date of Renewal: ______________________

% **IDENTIFICATION:**

NAME: ____
Last, First Middle (Maiden)

OTHER NAMES / ALIASES____

Sex: M [ ] F [ ] Date of Birth:____________________SOCIAL SECURITY #:______________________

PHYSICAL ADDRESS: BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB

MAILING ADDRESS: BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB

CURRENT PRACTICE / CLINIC ADDRESS: BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBEmail:BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB

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

WORK PHONE: BBBBBBBBBBBBBBBBBBBBBBBHOME PHONE: BBBBBBBBBBBBBBBBBBBBBBBCELL PHONE:BBBBBBBBBBBBBBBBBBB

C. Discipline for Which You Are Seeking License Renewal:

___Acupuncturist
___Audiologist
___Chiropractor
___Clinical Psychologist
BBB1XVLQJRPH$GPLQVWUDWRU
___Licensed Mental Health Counselor
___Licensed Professional Counselor
___Marriage & Family Therapist
___ Nutritionist/Clinical Dietitian
___Occupational Therapist
BB2FFXSDWLRQDO7KHUDSLVW$VVLVWDQW
___Physical Therapist
___Physical Therapist Asst.
___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. 0DVWHUV/HYHO
BBBB9HWHULQDU\0HGLFLQH

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

E. 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

F. 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		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)

Revised: 09/03/20

BOARD OF ALLIED HEALTH EXAMINERS

Suite 213A Terlaje Bldg., 194 Hernan Cortez Ave., 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: 09/03/20

Guam Board of Allied Health Examiners

Mailing and Physical Address: Suite 213A 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)*:

__Acupuncturist
__Audiologist
__Chiropractor
__Clinical Psychologist
__Euthanasia Technician (Certificate)
__Nursing Home Administrator
__Licensed Mental Health Counselor
__Licensed Professional Counselor
__Marriage & Family Therapist
__ Nursing Home Administrator
__ Nutritionist/Clinical Dietitian
__ Occupational Therapist
__ Occupational Therapist Assistant
__ Physical Therapist
__ Physical Therapist Assistant
__ Physician Assistant
__ Podiatrist Medicine
__ Respiratory Therapist, Certified
__ Respiratory Therapist, Registered
__ Respiratory Therapist, Technician
__ Speech Language Pathologist
__ Speech Language Asst. ***(Bachelor's Level)***
__ Speech Language Asst. ***(Master's Level***)
__ Veterinary 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 213A Terlaje Bldg.
194 Hernan Cortez Ave., Hagatna, Guam 96910

RECORD OF PAYMENT

CASHIER'S COPY

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)*:

__Acupuncturist
__Audiologist
__Chiropractor
__Clinical Psychologist
__Euthanasia Technician (Certificate)
__Nursing Home Administrator
__Licensed Mental Health Counselor
__Licensed Professional Counselor
__Marriage & Family Therapist
__Nursing Home Administrator
__Nutritionist/Clinical Dietitian
__Occupational Therapist
__Occupational Therapist Assistant
__Physical Therapist
__Physical Therapist Assistant
__Physician Assistant
__Podiatrist Medicine
__ Respiratory Therapist, Certified
__ Respiratory Therapist, Registered
__ Respiratory Therapist, Technician
__ Speech Language Pathologist
__ Speech Language Asst. (***Bachelor's Level***)
__ Speech Language Asst. (***Master's Level***)
__ Veterinary 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

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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

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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: ______________