Department of Public Health & Social Services

GUAM BOARD OF EXAMINERS FOR DENTISTRY

Mailing Address: 213A Terlaje Bldg., 194 Hernan Cortes Ave., Hagatna, Guam 96910

Dear Doctor:

The enclosed forms and instructions are for your review and application for licensure to practice dentistry on Guam.

The Guam Board of Examiners for Dentistry meets on the third Wednesday of each month. Completed applications must be filed with the Health Professional Licensing Office a minimum of sixty (60) days prior to the date of examination, to include the report from the B&B Reporting Inc. You may click on the link below to submit application to run a background check.
https://bandbreporting.bgsecured.com/c/p/unsolicited_portal?guid=9wGSWFfby5WNIN0sM9jBgvZ2UNNmkPoo

The clinical examination is scheduled twice yearly in the months of August and February. Dates of the examination are available from the Board Secretary. The Board's written Jurisprudence Examination must be successfully completed to qualify for an oral examination and interview. Arrangements for the Jurisprudence Exam, Oral Examination and Interview are also made through the Board Secretary at the following address:

Guam Board of Examiners for Dentistry
Room 213A Terlaje Professional Bldg.
194 Hernan Cortes Ave.
Hagatna, Guam 96910
Phone: (671) 735-7408
Email: nicole.romero@dphss.guam.gov

It is the responsibility of each applicant to ensure that the GBED Secretary receives all necessary documents. The application is considered incomplete until all necessary documents are received by the GBED Secretary and all applicable fees have been paid.

In making application for licensure as a Dentist, the applicant authorizes the GBED to verify any or all information contained in the application and/or seek whatever additional information pertinent to the applicant's qualifications or character that it may deem proper.

Sincerely,

ANTONIO RAPADAS, DDS
Chairperson

Department of Public Health & Social Services
GUAM BOARD OF EXAMINERS FOR DENTISTRY
Mailing Address: 213A Terlaje Bldg., 194 Hernan Cortes Ave., Hagatna, Guam 96910

APPLICATION REQUIREMENTS FOR DENTAL LICENSURE

Requirements for Licensure

1. The applicant must be of good moral character.

2. The applicant must present to the Guam Board of Examiners for Dentistry (GBED) a notarized copy of the applicant's diploma, or evidence satisfactory to the Board, of a graduation from a U.S. dental school or college which has been approved by the GBED and accredited by the American Dental Association (ADA); OR if a foreign dental graduate, applicant must present evidence of satisfactory completion of either a two(2) year dental residency through a U.S. accredited hospital or university or certified completion of an American Dental Association (ADA) accredited dental specialty training program.

3. All applicants, including foreign dental graduates, must demonstrate to the Board that they have successfully passed a clinical dental examination in one of the fifty (50) states.

4. If an applicant has practiced in any U.S. jurisdiction(s), the applicant shall furnish:
   A. a notarized copy of the applicant's license(s) to practice Dentistry in that jurisdiction, and
   B. an affidavit from the Board(s) Dental Examiners verifying that applicant has been engaged in the legal and reputable practice of dentistry in that jurisdiction and for how many years.

5. A detailed "Practice Plan" stating the type of practice applicant will establish, where this practice will be conducted, and in what way the practice will benefit the community and meet a need in the dental care delivery system.

6. If the applicant is applying for a dental license on Guam for the first time, he must have passed Part I and Part II of the National Board of Dental Examiners examination as evidenced by a notarized copy of the results of the examination.

7. Successful completion of a Jurisprudence written Examination will be required of all applicants for dental licensure in the territory of Guam. The purpose of such examination is to ensure that practicing dentists in the territory are familiar with the regulations and laws governing their practice. The GBED or its representative, will administer the necessary examination, and score of seventy-five percent (75%) will be required to pass the examination. The examination shall be successfully completed prior to the date of the Oral Examination and Interview.

8. Payment of required non-refundable fee:

A. Application Fee	$ 500.00
B. Clinical Examination Fee	$2,000.00

9. Successful completion of a Clinical Examination of the applicants diagnostic and clinical skills, at the discretion of the GBED. The Clinical is given twice yearly in the months of February and August. Dates may be obtained from the Board Secretary.

10. The applicant must successfully pass an Oral Examination and Interview with the Board.

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DOCUMENTS REQUIRED FOR DENTAL APPLICATION

1. Notarized copy of diploma.
2. Notarized copy(s) of Dental license(s) to practice in a state, U.S. territory or foreign country.
3. Notarized copy of Part I and Part II of National Board of Dental Examiners examination.
4. If a foreign graduate, a notarized certificate proving that you have satisfactorily completed a two (2) year dental residency through a U.S. accredited hospital or university of certified completion of an American Dental Association (ADA) accredited dental specialty training program.
5. A detailed "Practice Plan" which bears the applicant's signature.
6. A certified copy of the transcript from the applicant's Dental school.
7. The applicant must submit proof that he has attended a total of 65 credit unit hours of Continuing Education. If the applicant has graduated from dental school within the past 24 months this requirement will be prorated by the Board.
8. Sworn affidavit(s) from the applicant's Secretary of Board of Dental Examiners that he has been in the legal and reputable practice of Dentistry and for what period of time. The Board requests this of all jurisdictions in which the applicant practiced dentistry.
9. A completed questionnaire on moral character and fitness of the applicants.
10. A notarized copy of the photograph and information page of your valid passport.
11. Signed copy of Release of Liability.

Notarization of Documents:

1. Add to or type on the copy of each document the following statement.

"I certify this document to be a true and unaltered copy of the original".

2. Have a Notary witness your signature under this statement with the appropriate seal and/or documentation.

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APPLICATION FOR DENTAL LICENSURE

_____
Date

Attach 2" X 2"

Photo Here

Print, sign and date the back side.

_____
Name Age Sex

_____
Date of Birth Place of Birth

_____
Mailing Address

_____
Residence Address

_____
Email Home Phone Cell Phone

EDUCATION

		DATE	DEGREE
HIGH SCHOOL			
COLLEGE			
DENTAL COLLEGE			
POST GRADUATE			

PROFESSIONAL EXPERIENCE

FROM	TO	LOCATION	TYPE OF PRACTICE	REASON OF LEAVING

List all jurisdictions in which you are licensed to practice dentistry. Give statement regarding any disciplinary actions or investigations on a separate sheet. _____

MEMBERSHIPS AND PROFESSIONAL ACTIVITY

Membership in ADA _____ Specialty Organization Membership_____

Local Dental Societies _____ Other Professional Organizations _____

In making application for licensure as a Dentist, I authorize the GBED to verify any or all information pertinent to my qualifications or character that it may deem proper. I certify under penalty of perjury, to the truth and accuracy of all statements, answers and representation made.

_____
SIGNATURE

Department of Public Health & Social Services

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CERTIFICATION OF DENTAL EDUCATION

The applicant below is applying for licensure to practice dentistry in the territory of Guam. Please supply the following information and an official copy of the applicant's transcript and return directly to the Guam Board of Examiners for Dentistry at the address below.

TO BE COMPLETED BY THE APPLICANT

Legal Name: Last First Middle

Previous Name Used: Last First Middle

Social Security # Date of Birth

I hereby authorize release of a copy of my Academic Record to the Guam Board of Examiners for Dentistry.

_____ _____

Signature Date

TO BE COMPLETED BY THE SCHOOL ADMINISTRATOR

Applicant's Name:

Last, First Middle

Maiden or other Name: *Last, First Middle*

School of Dentistry

Address

1) Was the Dental School or Graduate training program approved by the ADA at the time of the applicant's enrollment? _____
2) If a foreign Dental school, by what agency was the dental training program approved? _____
3) The applicant was enrolled in the training program from _____ to _____
4) Number of Theory Hours _____ Number of Clinical Hours _____
5) Grade Point Average _____ Class Rank _____
6) Attach an Official copy of the applicant's transcript.

PLACE FOR OFFICIAL SEAL

_____

Name of Verifier Title

_____

Date Signature

Department of Public Health & Social Services

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VERIFICATION OF DENTAL LICENSURE

INSTRUCTIONS

1. Applicant completes top part of this form in block letters or type.
2. Send a copy of this form to all jurisdictions in which you have been licensed to practice dentistry.
3. The licensure Boards will return this form directly to the Guam Board of Examiners for Dentistry.

TO BE COMPLETED BY THE APPLICANT

Legal Name:

_____

Last, *First* *Middle*

_____

Street Address *City* *State* *Zip code*

LICENSE INFORMATION

State	*License Number*	*Date Issued*

I hereby authorize the licensing authority to furnish the Guam Board of Examiners for Dentistry the requested information.

_____ _____

Signature of Applicant *Date*

TO BE COMPLETED BY THE BOARD ADMINISTRATOR

1. License Number: _____ Date issued: _____
2. License Status: _____Active _____Inactive _____ Lapsed
3. Date of Expiration: _____
4. Was this license ever encumbered in any way? (revoked, suspended, surrendered, restricted, limited or placed on probation) ____ No _____ Yes. If yes, please provide information on separate sheet.
5. Are any investigations or disciplinary actions in process for this licensee? ____Yes ___No

_____

Name of Verifier *Title*

PLACE FOR
OFFICIAL SEAL

_____

Signature *Date*

GBED: 07/12/2021

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CONTINUING DENTAL EDUCATION (CDE) REQUIREMENTS

In compliance with Public Law 16-123, its revisions and the Rules and Regulations of the Guam Board of Examiners for Dentistry, all persons applying for initial dental licensure or renewal of dental license issued by the Board must verify their Continuing Dental Education credits to the Board. The minimum number of credits required each **24** months period is **65** hours.

Category I Continuing Education Credits are credits earned through attendance at State, National, and International dental meetings, Continuing Education courses accredited by the American Dental Association and other CDE activities approved in advance by the GBED. The GBED will determine the CDE credits earned for these other CDE activities.

Category II Continuing Education Credits are credits earned by attendance at regularly scheduled monthly meetings of the Guam Dental Society only. Two CDE credits will be awarded for each Guam Dental Society meeting attended.

NEW APPLICANTS

A new applicant must provide proof that they have attended a total of 65 credit hours of **Category I** Continuing Education credits within the previous 24 months. In the case of an applicant who graduated from a dental training program with the previous 24 months, the GBED will prorate the above Continuing Dental Education requirement.

APPLICANTS FOR RENEWAL

An applicant for renewal must document by September 30 or each odd numbered year to the GBED that they have attended a minimum of **65** credit hours of Continuing Dental Education. Of this total a minimum of **20** CDE credits must be **Category II** Continuing Dental Education credits. If a dentist has been licensed in the territory less than 24 month, the GBED will prorate the above Continuing Dental Education requirement.

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CONTINUING DENTAL EDUCATION REPORTING FORM

			HOURS	
COURSE/ACTIVITY/PROGRAM	**SPONSOR**	**DATES**		
		Total Hours:		

I certify under penalty of perjury to the truth and accuracy of all statements, answers and representations made in this report.

_____

Signature

_____

Date

GBED: 07/12/2021

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QUESTIONNAIRE ON MORAL FITNESS AND CHARACTER

Name of Applicant:_____ Date:_____

Please indicate **YES** or **NO** and **INITIAL** each question with a check mark.

All **YES** answers to the following questions must be accompanied by a written statement with dates explaining the circumstances and must be acceptable to the Board.

		YES	NO	INITIAL
1.	Has any jurisdiction of the United States, Territory or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a professional license you held?			
2.	Are there any charges or an investigation currently pending relative to your dental license in any state or territory?			
3.	Have you been charged, convicted, found guilty of any felony or misdemeanor or been found guilty of a crime, except for minor traffic violations, under the laws of any state, territory or foreign country?			
4.	Has any disciplinary action been taken against you by a government agency, law enforcement agency, any peer review body, health-care institution, or professional dental society regarding your clinical or ethical performance as a dentist in any state, territory or other nation?			
5.	Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished or subject to other disciplinary or probationary conditions?			
6.	Have you ever voluntarily surrendered a license issued to you by any professional licensing agency or limited you license to practice dentistry in any state or territory?			
7.	Have you ever entered into any stipulated agreement with any licensing or regulatory agency?			
8.	Have you been denied a narcotic license, charged or convicted of a violation of Federal, state, or territorial narcotic laws, or had a narcotic license restricted or asked to surrender it?			
9.	Have your staff privileges an any hospital or health-care institution been denied, reduced or removed, or have been subject to disciplinary action for reasons pertaining to your clinical or ethical performance as a dentist?			
10.	Have you voluntarily resigned or limited your staff privileges at any hospital or health-care institution while under formal or informal investigation by the institution or a committee thereof?			
11.	Have you voluntarily resigned or withdrawn from a national state, or country dental society, association or organization while under formal or informal investigation by the body?			

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Questionnaire Cont'd.

		YES	NO	INITIAL
12.	Are there any malpractice claims/complaints and or any professional liability suits in process/pending against you?			
13.	Have any judgments been entered against you resulting from your practice of dentistry?			
14.	Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?			
15.	Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?			
16.	Have you had or do you have any pending liability judgments, or out-of-court settlements relating to your practice of dentistry?			
17.	Are you addicted to the use of controlled substances, narcotics, barbiturates, or any other drugs?			
18.	Are you an alcoholic or do you use alcohol in any habitual manner that could affect your performance as a dentist?			
19.	Do you presently have any physical or mental health condition that could affect your ability to practice the profession of dentistry?			
20.	Since your last dental license renewal, have you been hospitalized or received any type or institutional care?			
21.	Have you failed to perform any statutory or legal obligation imposed upon you?			

Under penalty of perjury if a license is granted by this board, it will be based in part on the truth to the questions and of any statements contained herein, which, if false, may constitute grounds for denial, suspension or revocation of your license to practice dentistry on Guam.

_____
Initial

This form, when completed, must be submitted with your application for dental licensure.

_____ _____
Signature ***Date***

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RELEASE OF LIABILITY

In consideration for the evaluation, or re-evaluation of my application, credentials and qualifications for the purpose of licensure or certification in the territory of Guam, I hereby consent to the release of the following information to the Guam Board of Examiners for Dentistry (GBED):

1. Any and all information received from or held by administrators and members of the staff of institutions or dental licensing agencies.
2. Any and all documents held at other institutions, that may be pertinent to the evaluation or re-evaluation of my ability or qualifications to provide dental services.
3. Any and all information received from or held by my past and present malpractice insurance carriers with respect to my malpractice claims.
4. Any and all information held by attorneys who have represented me or my insurance carrier in my malpractice claims.

In consideration for the evaluation, or re-evaluation, of my application, credentials and qualifications for the purpose of licensure or certification, I hereby release from liability the Guam Board of Examiners for Dentistry (GBED) who have received information and release from liability all individuals and organizations who may provide information to the GBED, in connection with the evaluation or re-evaluation of my application.

In making application for licensure or certification, I authorize the Guam Board of Examiners for Dentistry (GBED) to verify or request any or all information pertinent to my qualifications or character that it may deem proper.

I agree that a photocopy of this release shall have the same force and effect as the original and may be sent to each individual and institution from whom information is requested.

_____ _____

Signature ***Date***

_____

Print Name

Department of Public Health & Social Services

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RECORD OF PAYMENT

I. IDENTIFICATION:

Name: _____
(*Last*) (*First*) (*Middle*)

Age:_____ Gender: M / F Date of Birth: _____ Place of Birth:_____State:_____

Mailing Address:_____

City: _____Apt./Ste.:_____ State/Terr:_____Zip code:_____

Primary Email: _____Secondary Email:_____

Residence Address:_____

City: _____Apt./Ste.:_____ State/Terr.:_____Zip code_____

Primary Tel: _____Secondary Tel:_____Other:_____

Name of Dental practice/Business:_____

Street Address:_____Apt./Ste:_____

City:_____Zip:_____ Bus. Phone:_____ Ext:_____

Bus. Fax:_____ Bus. Email: _____ Supervising Dentist:_____

Applicant's Signature: _____ Date: _____

II. VERIFICATION OF LICENSURE: *Please print the complete name used in original license AND your Social Security Number:* Name:_____ SS #: _____

III. FEES: *Please make all checks or money orders payable to the* ***Treasurer of Guam.*** *All fees are* ***NON-REFUNDABLE.***

Please check your requests below

A. DENTISTS:

	Clinical Examination Fee	$2000.00
	Dental License Initial Application Fee	500.00
	Dental License Renewal Application Fee	200.00
	Late Filing Fee for Dental License Renewal Application (per month) ***after 31 August***	200.00
	License Verification Fee	25.00
	Re-issuance of License Certificate	50.00
	Copy of Guam Dental Practice Act(http://www.guamcourts.org/compilieroflaws/GCA/10gca/10gc012.PDF) pp. 68-84	20.00
	Copy of GBED Rules and Regulations (http://www.guamcourts.org/compileroflaws/GAR/25GAR/25GAR001-8.PDF)	20.00
	Photocopy *(per page)*	0.50
	Specialty License Initial Application Fee	200.00
	Specialty License Renewal Fee	100.00
	Initial Application for Use of Permit for Analgesia, Sedation & General Anesthesia	100.00
	Renewal for Use of Permit for Analgesia, Sedation & General Anesthesia	20.00

B. HYGIENISTS:

	Dental Hygiene License Initial Application Fee	$100.00
	Dental Hygiene License Renewal Application Fee	50.00
	Late Fee for Dental Hygiene License Renewal ***after 30 September***	50.00
	Initial Application for Permit to Administer Local Anesthesia	50.00
	Renewal of Permit to Administer Local Anesthesia	50.00

C. ANCILLARY DENTAL PERSONNEL ***(Check one:*** **[ ] Dental Assistant [ ] Dental Lab Technician [ ] Dental Auxiliary)**

	Dental Ancillary Personnel Initial Registration Fee	$50.00
	Dental Ancillary Personnel Renewal of Registration Fee	30.00
	Late Fee for Dental Ancillary Personnel Renewal of Registration ***after 30 September***	50.00

NOTE: Present this Form and make payments at the cashier in the GITC bldg. or Public Health **TOTAL AMOUNT DUE:**

FOR OFFICE USE ONLY: Payment: ( ) Cash ( ) Check ( ) Money Order

Field Receipt: _____ **Date Paid:** _____

GBED: 07/12/2021