



GUAM BOARD OF MEDICAL EXAMINERS

APPLICATION CHECKLIST FOR FULL MEDICAL LICENSE

Name: _____ Date of Application: _____

Specialty: _____

- _____ Guam Board of Medical Examiners form 1 (**GBME-1**) application.
- _____ Photo-signed and dated, taken within the past six (6) months.
- _____ Guam Board of Medical Examiners form 7 (**GBME-7**) for record of payment.
- _____ Guam Board of Medical Examiners form 9 (**GBME-9**) for CME Report. (2019 & Current)
- _____ Guam Board of Medical Examiners form 11 (**GBME-11**) for interview questionnaire.
- _____ Guam Board of Medical Examiners form 21 (**GBME-21**) for release of information.
- _____ Federation Credential Verification Service (**FCVS**) for primary source verification; to be sent directly to GBME.
- _____ Certificate of Medical Education Form (**GBME-3**), if not submitting FCVS primary source verification.
- _____ Certificate of Internship/Residency Program Form (**GBME-4**) if not submitting FCVS primary source verification.
- _____ Hospital/Practice Verification (**GBME-5.0**) if not submitting FCVS primary source verification.
- _____ State Board Verification (**GBME-5.2**)
- _____ Qualifying Examination Certificates that you have completed in accordance to GBME requirements for each new applicant: FLEX; NBME; USMLE; OTHER.
- _____ National Practitioner Data Bank self-query sent directly to GBME.
- _____ Notarized copy of ECFMG certificate for foreign medical graduates or original certificate sent directly to GBME.
- _____ American Medical Association (**AMA**) physician's profile sent directly to GBME.
- _____ Detailed Practice Plan. (*Employer on Guam*)

NOTE: If required items are not submitted with application, then the application will be considered incomplete and will not be processed until all items requested are received.



GUAM BOARD OF MEDICAL EXAMINERS

APPLICATION FOR INITIAL FULL MEDICAL LICENSURE

**ATTACH
2 X 2
PHOTO
HERE**

GENERAL INFORMATION AND INSTRUCTIONS

1. Please type or print.
2. Unsigned application shall be considered incomplete and will be returned for signature.
3. Application must include the following: **Completed check list: GBME-1, GBME-7, GBME-9, GBME-11, GBME-21 Forms, and payment.**
4. Make Check or Money Order payable to *"Treasurer of Guam"* and mail to:
194 Hernan Cortez Ave., Suite 213, Hagatna, GU 96910

A. IDENTIFICATION:

1. NAME: _____
(LAST) (FIRST) (MIDDLE) (MAIDEN)
2. SOCIAL SECURITY NO.: _____ SEX: _____ M _____ F
3. DATE OF BIRTH: _____ PLACE OF BIRTH: _____
4. PERMANENT ADDRESS: _____

5. MAILING ADDRESS: _____
(STREET OR P.O. BOX)

(CITY) (STATE) (ZIP CODE)
6. EMAIL ADDRESS: _____ CONTACT #: _____
(MANDATORY — for contact purposes only)

B. EDUCATIONAL INFORMATION:

EDUCATIONAL BACKGROUND	NAME & ADDRESS	DATE GRADUATED	DEGREE
COLLEGE/UNIVERSITY			
MEDICAL SCHOOL			
POST GRADUATE TRAINING <small>(Only list ACGME or AOA approved internship, residency and fellowships(s))</small>			



GUAM BOARD OF MEDICAL EXAMINERS

C. PROFESSIONAL INFORMATION:

1. List *past and current* medical license for the United States and its Territories and Canada:

2. EXAMINATIONS TAKEN (List only if passed and list all parts and dates taken if applicable):

ECFMG: _____
FLEX: Component 1: _____ Component 2: _____
NBME: Part 1: _____ Part 2: _____ Part 3: _____
USMLE: Part 1: _____ Part 2: _____ Part 3: _____

3. Professional Experience as a physician over the last five (5) consecutive years:

FROM	TO	LOCATION	TYPE OF PRACTICE	REASON FOR DISCONTINUATION

4. ABMS (American Board of Medical Specialties) Specialty Certification:

a. I am ABMS (American Board of Medical Specialties) BOARD CERTIFIED in the following:

<u>Specialty</u>	<u>Date Issued</u>	<u>Date Expired</u>
------------------	--------------------	---------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

(NOTE: ATTACH COPY OF EACH ABMS BOARD CERTIFICATION)

5. My area of practice is/are: _____

D. AFFIDAVIT: TO BE SWORN BEFORE AN OFFICER AUTHORIZED TO ADMINISTER OATHS BY THE APPLICANT WHO HAS COMPLETED THIS FORM, AND IS APPLYING FOR GUAM LICENSURE.

SUBSCRIBED AND SWORN TO BEFORE ME THIS

_____ DATE OF _____

NOTARY PUBLIC: _____

COMMISSION EXPIRES: _____

APPLICANT'S SIGNATURE

(NOTARY SEAL)



GUAM BOARD OF MEDICAL EXAMINERS

RECORD OF PAYMENT

I. IDENTIFICATION

Name: _____
(LAST) (FIRST) (MIDDLE)

Mailing: _____
(CITY) (STATE) (ZIP)

Signature: _____ Date: _____

II. Verification of Licensure: Please print the complete name used on original license and your Social Security Number

Name: _____ SSN: _____

Fee: Please make all check or money orders payable to **TREASURER OF GUAM**. All fees are **NON-REFUNDABLE**.

Please check your request(s):

1. ()	Application Fee	\$	150.00
2. ()	License Fee	\$	250.00
3. ()	USMLE Step 3 Examination	\$	530.00
4. ()	Temporary License	\$	125.00
5. ()	License Renewal	\$	250.00
6. ()	Late Renewal Penalty Fee	\$	150.00
7. ()	Inactive Status	\$	300.00
8. ()	Reinstatement of License	\$	400.00
9. ()	License Verification	\$	25.00
10. ()	Re-Issuance (duplicate) License Certificate	\$	100.00
11. ()	Re-Issuance (duplicate) License Card	\$	20.00
12. ()	Physicians Practice Act	\$	10.00
13. ()	Physicians Practice Act Admin. Rules & Regulations	\$	10.00
14. ()	Photocopy (up to five (5) pages)	\$	4.00
15. ()	Photocopy (each additional page)	\$.50

Interstate Medical Licensing Compact

1. ()	Application Fee	\$	150.00
2. ()	License Fee	\$	250.00
3. ()	Letter of Qualification	\$	300.00

NOTE: Mail this form to the: *Guam Board of Medical Examiners, 194 Hernan Cortez Ave. Suite 213, Hagatna, GU 96913*

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

Field Receipt No.: _____ Date Paid: _____

GMBE-7



GUAM BOARD OF MEDICAL EXAMINERS

CONTINUING MEDICAL EDUCATION REPORT

A. IDENTIFICATION

1. Name: _____
 (LAST) (FIRST) (MIDDLE) (MAIDEN)
2. SSN.: _____ Date of birth: _____
3. Guam License No.: _____ Expiration Date: _____

B. CME CATEGORIES AND REQUIREMENTS: A minimum of 100 credit hours of CME over the past two(2) years. Of this, at least a minimum of 50 Category I credit hours relevant in the field of your practice. (SEE REVERSE PAGE)

C. LISTING OF CONTINUING EDUCATION PARTICIPATION: (PLEASE PRINT OR TYPE)

Course Title	Sponsored By	Dates Attended	Accredited/Approved by (AMA, AAFP, ACOG, etc.)	Category	Credit Hours

Total No. of Credit hours Reported: _____

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

 (Signature of Physician)

 (Date)

ATTACH COPIES OF ALL CATEGORY I CERTIFICATES



GUAM BOARD OF MEDICAL EXAMINERS

CME (CONTINUING MEDICAL EDUCATION) CATEGORIES

- Category I: Continuing Medical Education activities accredited by the American Medical Association and other activities approved in advance by the GBME. A minimum of 50% of the credit hours reported should be in this category.
- Category II: Continuing Medical Education Activities with non-accredited sponsorship.
- Category III: Medical teaching credit may be claimed for contact hours of teaching of medical students, interns, residents, and allied health professionals.
- Category IV: Papers, Publications, Books and Exhibits; ten (10) credit hours may be claimed for each paper published or given before a medical audience.
- Category V: Credit hours may be claimed for time spent with Self-Instruction activities (journal reading, studying medical audiovisual material), patient care review and Self-Assessment Examinations.
- Category VI: Other Meritorious Learning Experiences: These activities that do not fit into the other five (5) categories, but which the applicant feels represent valid continuing medical education. Submit a description of the activity for review by the Board.

CME REQUIREMENTS

1. **Initial application for full licensure:**
 - a. A minimum of 100 credit hours of CME over the past two (2) years. Of this, at least 50% (50 credits) must be in Category I. (Attach copies.)
2. **Renewing a full medical license:**
 - a. A minimum of 100 credit hours of CME over the past two (2) years. Of this, at least 50% (50 credits) must be in category I. (Attach copies.)
 - b. At least two (2) credit hours of category I CME must be in Medical Ethics course(s). (Attach copies.)

Note: The Physician's Recognition Award obtained from the American Medical Association will be recognized as category I credits. Completion of an ACGME accredited residency or fellowship within the last year prior to application for licensure will meet the GBME CME requirements. Verification of such training must be provided to the GBME.



GUAM BOARD OF MEDICAL EXAMINERS

INITIAL APPLICATION INTERVIEW QUESTIONNAIRE

PAGE 1 OF 2

Name of Applicant: _____

Date: _____

PLEASE INDICATE YES or NO and INITIAL each entry.

(All "YES" answers to the following questions must be accompanied by a written statement with dates explaining the circumstances that must be acceptable to the GBME)

	YES	NO	INITIAL
1 Has your license to practice medicine ever been revoked, suspended, or restricted Or has there been any disciplinary action taken against you in any state or territory?	_____	_____	_____
2 Have you ever been convicted of any felony or misdemeanor, except for minor traffic violations under the laws of any state or territory?	_____	_____	_____
3 Has any disciplinary action ever been taken against you by a government agency, Law enforcement agency, any peer review body, healthcare institution, or professional Medical society regarding your clinical or ethical performance as a physician?	_____	_____	_____
4 Have you voluntarily surrendered your medical license while under investigation in any state or territory?	_____	_____	_____
5 Have you ever been licensed or privileged to practice medicine by a government Jurisdiction including the military, public health or foreign government.	_____	_____	_____
6 Have you ever been denied a narcotic license, charged or convicted of a violation Of a Federal, State or Territorial Narcotic Laws, or asked to surrender your narcotic license?	_____	_____	_____
7 Has your staff privileges at any hospital/healthcare institution ever been denied, reduced or removed, or have you ever been subject to disciplinary action for reasons pertaining to your clinical or ethical performance as a physician?	_____	_____	_____
8 Have you ever voluntarily resigned or limited your staff privileges at any hospital/Health care institution while under formal or informal investigation by the institution or a committee thereof?	_____	_____	_____
9 Have you ever voluntarily resigned or withdrawn from a nation state or county medical society, association or organization while under a formal or informal investigation by the institution or a committee thereof?	_____	_____	_____



GUAM BOARD OF MEDICAL EXAMINERS

CONTINUATION OF INITIAL APPLICATION INTERVIEW QUESTIONNAIRE PAGE 2 OF 2

	YES	NO	INITIAL
10 Have you ever had a liability judgments(s) or/and legal settlement(s)?	_____	_____	_____
11 Have you ever changed your practice specialty?	_____	_____	_____
12 Have you ever been addicted to the use of narcotics, barbiturates, alcohol or other drugs	_____	_____	_____
13 Do you presently have a physical or mental health condition that can affect or is reasonably likely to affect your ability to perform your medical duties or affect your clinical judgment?	_____	_____	_____
14 Have you ever been licensed or applied for licensure on Guam? If "YES" Please indicate date: _____	_____	_____	_____

Under penalty of perjury, any misrepresentation to the Guam Board of Medical Examiners can constitute grounds for denial suspension or revocation of your medical license and prosecution to the full extent of the laws of Guam.

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

Signature

Date

Name and Signature of Reviewing Board Representative
Guam Board of Medical Examiners

Date



GUAM BOARD OF MEDICAL EXAMINERS

I, _____, do hereby authorize the Guam Board of Medical Examiners to request information from appropriate individual/agency/organization to verify my qualifications and/or current licensure standing with other Medical Boards.

I understand that request for verifications will be forwarded in accordance to the established administrative rules and regulations.

(Signature)

(Date)



GUAM BOARD OF MEDICAL EXAMINERS

CERTIFICATE OF MEDICAL EDUCATION

THE APPLICANT BELOW IS APPLYING FOR LICENSURE TO PRACTICE MEDICNE IN GUAM. PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN ***DIRECTLY TO THE BOARD AT 194 Hernan Cortez Ave., Suite 213, Hagatna, GU 96910***

PART A — TO BE COMPLETED BY APPLICANT

- Current Name: _____
(Last) (First) (Middle) (Maiden)
- Previous Name Used: _____
(Last) (First)
- Social Security No.: _____ Date of Birth: _____

I HEREBY AUTHORIZED RELEASE OF A COPY OF MY ACADEMIC RECORD TO THE GUAM BOARD OF MEDICAL EXAMINERS.

(Signature) (Date)

PART B — TO BE COMPLETED BY THE MEDICAL SCHOOL ADMINISTRATOR: INDICATE (X) WHERE APPLICABLE.

- Name of Applicant: _____
(Last) (First) (Middle) (Maiden)
- School of Medicine: _____

(City) (State) (Zip)
- WAS THE SCHOOL BOARD APPROVED OR STATE REGULATORY AGENCY APPROVED DURING THE APPLICANT'S ENROLLMENT? () YES () NO
IF YES, BY WHOM: _____
- WAS THE APPLICANT A GRADUATE FROM COLLEGE? () YES () NO
- THE APPLICANT ENTERED THE MEDICAL PROGRAM ON _____ AND COMPLETED THE _____ MONTHS PROGRAM ON _____
- ATTACHED IS THE OFFICIAL COPY OF APPLICANT TRANSCRIPT.**

SEAL	SIGNATURE: _____
OF	NAME: _____
SCHOOL	TITLE: _____



GUAM BOARD OF MEDICAL EXAMINERS

CERTIFICATE OF INTERNSHIP/RESIDENCY PROGRAM

THE APPLICANT BELOW IS APPLYING FOR LICENSURE TO PRACTICE MEDICINE IN GUAM. PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN ***DIRECTLY TO THE BOARD AT 194 Hernan Cortez Ave., Suite 213, Hagatna, GU 96910***

PART A — TO BE COMPLETED BY APPLICANT

- Current Name: _____
(Last) (First) (Middle) (Maiden)
- Previous Name Used: _____
(Last) (First)
- Social Security No.: _____ Date of Birth: _____

I HEREBY AUTHORIZED RELEASE OF A COPY OF MY ACADEMIC RECORD TO THE GUAM BOARD OF MEDICAL EXAMINERS.

(Signature) (Date)

PART B - TO BE COMPLETED BY THE AUTHORIZED PERSON WITHIN THE INSTITUTION.

- Name of Applicant: _____
(Last) (First) (Middle) (Maiden)
- Name of Institution: _____
- Address of Institution: _____

(City) (State) (Zip)
- The above named applicant started the _____ INTERNSHIP/_____ RESIDENCY _____ program from _____ to _____ to a total of _____ months.
- During this period said applicant carried out performance:
_____ Satisfactory and without filed complaints
_____ Unsatisfactory — Explain on separate sheet

I CERTIFY THAT THE INFORMATION PROVIDED ARE TRUE UNDER PENALTY OF PERJURY TO THE TRUTH AND ACCURACY OF STATEMENTS, ANSWERS AND REPRESENTATION MADE IN SUPPORT OF ABOVE NAMED APPLICANT SEEKING LICENSE TO PRACTICE MEDICINE ON GUAM.

(Signature) (Date) (Print Name)

(Title)



GUAM BOARD OF MEDICAL EXAMINERS

Applicant to send to hospital/organization and is responsible for all fees and charges.

My signature below is your authority to release any and all information in your files favorable or otherwise regarding myself, directly to:

Department of Public Health & Social Services
Health Professional License Office
194 Hernan Cortez Ave., Suite 213
Hagatna, Guam 96910

Signature

HOSPITAL VERIFICATION / PRACTICE VERIFICATION

Applicant's Name: _____

Date of Birth: _____

Hospital: _____

Address: _____

Position(s) Held: _____

Committees, Department: _____

Was there any adverse information occurrence during hospital affiliation?:

Name of Verifier: _____
(Print)

Title: _____

Signature: _____

Date: _____

SEAL

GBME-5.0



GUAM BOARD OF MEDICAL EXAMINERS

*Applicant is requested to please complete this section of the form and mail to **each State Board** by which you are **now or have been** licensed to practice medicine/osteopathy. If needed, you may copy this form for additional copies.*

To Whom It May Concern:

In applying for a license to practice medicine/osteopathy in Guam, the Guam Board of Medical Examiners requires this form completed by each state wherein I hold or have ever held licensure. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself, directly to:

Department of Public Health & Social Services
Health Professional Licensing Office
194 Hernan Cortez Ave., Suite 213
Hagatna, GU 96910

Name: _____
Address: _____

License No.: _____

(Signature)

State of: _____

License No.: _____

Effective Date: _____

By Endorsement/Reciprocity with: _____

By Your State Board's Written Examination: _____

Is License Current? _____ If NO, Why Not? _____

Has the Physician ever been disciplined by your Board in any manner (revocation, probation, suspension, etc.)? _____

If YES, please explain and attach a copy of final order _____

Are there currently any formal charges pending against this physician's license? _____ If YES, please explain and attach a copy of complaint? _____

Is the Physician currently under investigation, or has he/she been investigated for any serious matter in the past five (5) years? _____ If YES, Please explain: _____

Has licensee ever been requested to appear before your Board? _____ If YES, please explain: _____

Additional comments, if any: _____

(Board Seal)

Name of Verifier: _____
Title: _____
Signature: _____
Date: _____