GUAM BOARD OF MEDICAL EXAMINERS

APPLICATION FOR REINSTATEMENT LICENSE CHECKLIST

Name: _____ Date of Application: _____

Specialty: _____

_____ Guam Board of Medical Examiners Application (GBME-8a)

_____ Photo 2x2 (print, sign, & date), taken within the last three (3) months

_____ Notarized copy (ies) of Medical License(s)
- _____ Continental U.S.
- _____ U.S. Territories

_____ National Practitioner Data Bank

_____ Interview Questionnaire (GBME-11)

_____ Records of Payment Form (GBME-7)
Reinstatement of License Fee ($400.00)

GUAM BOARD OF MEDICAL EXAMINERS

APPLICATION FOR REINSTATEMENT OF MEDICAL LICENSE

ATTACH 2 X 2 PHOTO HERE

A. GENERAL INFORMATION AND INSTRUCTIONS

1. Please type or print.
2. Verification of continued competency includes employment verification. One Hundred (100) Hours of approved CMEs within the current renewal period **(50 HOURS MUST BE IN CATEGORY I)** is also required at the time of application for reinstatement of a license that has lapsed or have been in inactive status for less than six (6) years.
3. Reinstatement Fee of $400.00.
4. Unsigned application shall be considered incomplete and will be returned for signature prior to processing.
5. Submission of completed application include:

   a. GBME-5.0 b. GBME-7 c. GBME-8a d. GBME-9
6. Make Check or Money Order payable to ***"Treasurer of Guam"*** and mail to:
   194 Hernan Cortez Ave. Suite 213, Hagatna, Guam 96910

B. IDENTIFICATION:

1. NAME: _____
   (LAST) (FIRST) (MIDDLE) (MAIDEN)

2. DATE OF BIRTH: _____ SSN: _____

3. GUAM MEDICAL LIC. NO.: _____ EXPIRATION DATE: _____

4. MAILING ADDRESS: _____
   (STREET ADDRESS)

   _____
   (CITY) (STATE) (ZIP CODE)

5. WORK ADDRESS: _____
   (STREET ADDRESS)

   _____
   (CITY) (STATE) (ZIP CODE)

C. SPECIALTY

My area of practice is/are: _____

1. I became BOARD ELIGIBLE in the following:

Area of Practice	**Date**
_____	_____
_____	_____
_____	_____

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2. I am BOARD CERTIFIED in the following:

Specialty	Date Issued	Expiration Date

(NOTE: ATTACH COPY OF EACH UPDATED CERTIFICATE OF BOARD CERTIFICATION)

D. CONTROLLED SUBSTANCE CERTIFICATION

1. Guam Registration No.: _____ Expiration Date: _____

2. DEA No. Expiration Date: _____ Expiration Date: _____

3. Schedule:

II	Narcotic	YES	NO
	Non-Narcotic	YES	NO
III	Narcotic	YES	NO
	Non-Narcotic	YES	NO
IV		YES	NO
V		YES	NO

E. FELONIES AND CONVICTIONS

(Please circle - (Y) Yes, (N) No for each question) * YES RESPONSE(S) MUST BE EXPLAINED IN A SEPARATE SHEET.

Y N 1. Have you had any liability judgment or out of court settlement for Malpractice or Medical Battery?

Y N 2. Have you had any disciplinary action by any local or state professional society, licensing agency or other regulatory agency?

Y N 3. Have you voluntarily surrendered or limited your license to practice medicine in any state, U.S. territory or foreign government?

Y N 4. Have you ever been denied a license or authorization to practice medicine by any jurisdiction, including the military, public health or foreign government?

Y N 5. Have you had suspension or revocation of a Narcotics Registration?

Y N 6. Have you ever voluntarily resigned or limited your staff privileges at any hospital/healthcare institution?

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Y N 7. Have you ever voluntarily resigned or withdrawn from a nation, state or country medical society, association or organization while under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct, mental or physical impairment?

Y N 8. Have you ever been denied a narcotic license, charged or convicted of a violation of Federal, State or Territorial Narcotic Laws or asked to surrender your narcotic license?

Y N 9. Have you abused or have been addicted to or treated for addiction to alcohol or any chemical substance during the registration period?

Y N 10. Have you had any physical injury, disease or mental illness that affect or interrupt your practice of medicine within the registration period?

F. OTHER STATES OR U.S. TERRITORIES WHERE YOU ARE CURRENTLY LICENSED: _____

_____

G. EMPLOYMENT HISTORY:

LIST LAST THREE (3) EMPLOYERS:

EMPLOYER	ADDRESS	DATE
1.		
2.		
3.		

H. AFFIDAVIT: TO BE SWORN BEFORE AN OFFICER, AUTHORIZED TO ADMINISTER OATHS BY LICENSEE WHO HAS COMPLETED THIS FORM FOR REINSTATEMENT FOR GUAM LICENSURE.

_____ _____

Signature Date

SUBSCRIBED AND SWORN TO, BEFORE ME THIS
_____DAY OF _____
NOTARY PUBLIC:_____
COMMISSION EXPIRES: _____
(DATE)

N O T A R Y P U B L I C

S E A L

GBME-8a Rev. 12/2019

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

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CME (CONTIUING 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 50 credit hours (relevant in the field of your practice) of CME over the past two (2) years 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.

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INITIAL APPLICATION INTERVIEW QUESTIONAIRE

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?	___	___	_____

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

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CONTINUATION OF INITIAL APPLICATION INTERVIEW QUESTIONAIRE
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

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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: _____

SEAL

Signature: _____

Date: _____

GBME-5.0

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***. *Online payments* can be made at www.guamhplo.org/gbme (additional 5% convenience fee).
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***

ACCOUNT #: 324156343
FOR OFFICE USE ONLY: Payment ( ) Check ( ) Money Order
Field Receipt No.: _____ Date Paid:

GMBE-7