GUAM BOARD OF MEDICAL EXAMINERS

APPLICATION CHECKLIST
FOR
REINSTATEMENT OF LICENSE

Name: _____ Date of Application: _____

Specialty: _____

_____ Guam Board of Medical Examiners form 1 **(GBME-8a)** application.

_____ Photo – Signed and Dated, taken within the past six (6) months.

_____ Guam Board of Medical Examiners Form **(GBME-7)** for record of payment.

_____ Guam Board of Medical Examiners Form **(GBME-9)** for CME Report. (2022, 2023, & 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.

_____ Notarized copy of Medical License(s)

_____ Continental U.S.

_____ U.S. Territories

_____ National Practitioner Data Bank self-query sent directly to GBME.

_____ Detailed Practice Plan. ***(Employer on Guam)***

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

GUAM BOARD OF MEDICAL EXAMINERS

APPLICATION FOR REINSTATEMENT OF LICENSURE

ATTACH 2x2 PHOTO HERE

GENERAL INFORMATION AND INSTRUCTIONS

1. Please type or print.
2. Unsigned applications shall be considered incomplete and will be returned for signature.
3. Applications must include the following: **Completed checklist: GBME-7, GBME-8a, GMBE-9, GBME-11, GBME-21 Form, and payment**.
4. 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).

A. IDENTIFICATION:

1. NAME: _____ DATE OF BIRTH: _____
2. SOCIAL SECURITY NO.: _____ SEX: _____M _____F
3. PLACE OF BIRTH: _____ CONTACT NO.: _____
4. EMAIL ADDRESS: _____ NPI: _____
5. PRIMARY PRACTICE ADDRESS: _____

   _____
6. MAILING ADDRESS: _____

   _____

B. SPECIALTY & PROFESSIONAL EXPERIENCE:

My area of practice is/are: _____

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

Area of Practice	Date
_____	_____
_____	_____
_____	_____

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GUAM BOARD OF MEDICAL EXAMINERS

2. Professional Experience as a physician over the past five (5) consecutive years:

FROM	TO	LOCATION	TYPE OF PRACTICE	REASON FOR DISCONTINUATION

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

C. CONTROLLED SUBSTANCE CERTIFICATION

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

2. DEA No.: _____ Expiration Date: _____

3. Schedule:

II	Controlled	☐ YES	☐ NO
	Non-Controlled	☐ YES	☐ NO
III	Controlled	☐ YES	☐ NO
	Non-Controlled	☐ YES	☐ NO
IV		☐ YES	☐ NO
V		☐ YES	☐ NO

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

_____

E. EMPLOYMENT HISTORY: LIST LAST THREE (3) EMPLOYERS

	EMPLOYER NAME	ADDRESS	DATE
1.			
2.			
3.			

I declare under penalty of perjury that the foregoing is true and correct.

Applicant Signature: _____ **Date:** _____

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 #: 5211335
FOR OFFICE USE ONLY: Payment ( ) Check ( ) Money Order
Field Receipt No.: _____ Date Paid:

GMBE-7

GUAM BOARD OF MEDICAL EXAMINERS

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.

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

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?	___	___	_____

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GUAM BOARD OF MEDICAL EXAMINERS

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

Guam Board of Medical Examiners

Applicant Full Legal Name: _____
(First, Middle, Last, Suffix)

Date of Birth: _____
(mm/dd/yyyy)

I, _____ being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete Guam Board of Medical Examiners' application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct, to include all previously submitted documents; and that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, licensing boards, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Guam Board of Medical Examiners or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Guam Board of Medical Examiners or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I understand that such collection of information may include physical documents, electronically transmitted documents and verbal discussion in person, via phone or electronic devices, e.g., via the internet.

_____ _____
(Signature) (Date)

194 Hernan Cortez Ave. Suite 213, Hagåtña, GU 96910
(671) 735- 7405/8/10/11/12 ● Fax: (671) 735-7413