



# GUAM BOARD OF MEDICAL EXAMINERS

## APPLICATION CHECKLIST FOR SPECIAL 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. (2018 & 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.**



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## APPLICATION FOR SPECIAL 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
<b>COLLEGE/UNIVERSITY</b>			
<b>MEDICAL SCHOOL</b>			
<b>POST GRADUATE TRAINING</b> <small>(Only list ACGME or AOA approved internship, residency and fellowships(s))</small>			



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## 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

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### I. IDENTIFICATION

Name: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

Mailing: \_\_\_\_\_  
\_\_\_\_\_  
(CITY) (STATE) (ZIP)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### 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

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.

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(Signature)

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(Date)



# 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 50 credit hours 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 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?	_____	_____	_____





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## 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

*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