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. (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.

_____ 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
COLLEGE/UNIVERSITY			
MEDICAL SCHOOL			
POST GRADUATE TRAINING **(Only list ACGME or AOA approved internship, residency and fellowships(s)**			

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C. PROFESSIONAL INFORMATON:

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:

Specialty	**Date Issued**	**Date Expired**
_____	_____	_____
_____	_____	_____
_____	_____	_____

(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_____ APPLICANT'S SIGNATURE
NOTARY PUBLIC: _____
COMMISSION EXPIRES: _____

(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***. *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

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

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

GBME-9

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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 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

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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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

GBME-11

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