GUAM BOARD OF MEDICAL EXAMINERS

Department of Public Health & Social Services
194 Hernan Cortez Avenue, Terlaje Building, Suite 213, Hagatna, GU 96910

APPLICATION FOR LIMITED MEDICAL LICENSURE
INSTRUCTIONS AND REQUIREMENTS

IMPORTANT: Please adhere to the following instructions carefully to ensure timely processing of your application. Incomplete submissions may result in delays. If additional forms are required, please make copies as necessary. Allow up to 30 days from the submission date before inquiring about the status of your application. Should further information be needed, you will be contacted using the email or phone number provided in your application.

A checklist is included to assist in ensuring your submission is complete. Kindly verify that all required documentation is included and use the checklist to confirm completeness. The Board may request additional documentation to verify or support the information provided. Be sure to retain a copy of all documents submitted for your records.

REQUIREMENTS FOR LICENUSRE / SUMMARY OF CHECKLIST:

Section A **Limited Medical Licensure Application (GBME-3)**

Section B **2x2 Photo**

Section C **Record of Payment and Fee (GBME-7)**

Section D **Interview Questionnaire (GBME-11)**

Section E **Release of Information (GBME-21)**

Section F **Sponsorship Letter from a currently licensed Physician/Clinic**

Section G **Verification from Institution**

Section H **National Practitioner Data Bank (NPDB)**

Section I **Detailed Practice Plan**

Application Submission Address:

Guam Board of Medical Examiners
194 Hernan Cortez Avenue
Terlaje Professional Bldg., Suite 213
Hagatna, GU 96910

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CHECKLIST FOR FILING AN APPLICATION FOR LIMITED MEDICAL LICENSURE:

Section A Limited Medical Licensure Application (GBME-3)

1. This application is only for Physicians in Graduate Training.
2. Complete the entire application and submit with original signatures. Ensure the application is notarized. If an item or question is not applicable, indicate N/A.
3. Applications must include the following GBME forms: **GBME-3, GBME-7, GBME-11, and GBME-21**.
4. Please type or print.

Section B 2x2 Photo

1. Attach a **NEW** 2x2 passport-style photo to page 1 of the application taken within six (6) months of submitting the application.
2. **DO NOT** provide scanned images, Polaroids, or black-and-white photos.

Section C Record of Payment and Fee (GBME-7)

1. Complete the entire record of payment form and submit payment of the $150 Application Fee & $125 Temporary License Fee. Both fees are non-refundable.
2. Make all checks or money order payable to **'Treasurer of Guam'**.
3. Online payments may be made on the Board website at www.guamhplo.org/gbme/pay.

Section D Interview Questionnaire (GBME-11)

1. Complete the entire interview questionnaire form. Be sure to initial after each question in the space provided.
2. All **"YES"** answers (with the exception of question #15) to any of the questions must be accompanied by a written statement, including dates, explaining the circumstances.

Section E Release of Information (GBME-21)

1. Complete the entire release of information form. Be sure to carefully read the entire form before signing.

Section F Sponsorship Letter from a currently licensed Physician/Clinic

1. The letter should clearly state that the licensed physician or clinic is sponsoring the applicant for postgraduate training, whether it's for a fellowship, residency, or another specialized medical program.
2. The letter should provide the name and credentials of the licensed physician.
3. The letter must specify the purpose and expected dates of the sponsorship.
4. The sponsoring physician or clinic should affirm their willingness to assume responsibility for the candidate's progress and provide professional guidance throughout the training.
5. The letter must be signed and dated by the sponsoring physician.

Section G Verification from Institution

1. The institution supervising the applicant's postgraduate training program shall confirm that the applicant physician is in good standing with the institution and has not been subject to any disciplinary actions or investigations related to academic, clinical, or ethical matters.

Section H National Practitioner Data Bank (NPDB)

1. Submit an NPDB self-query directly to the Board. Submission via mail or email will suffice.

Section I Detailed Practice Plan

1. Provide a letter to the Board outlining your reasons for obtaining a Guam medical license. The letter should include the following information:
    - **Specialty** - Clearly state your medical specialty or area of practice (e.g., family medicine, cardiology, psychiatry, etc.).
    - **Years of Experience** - Provide an overview of your experience, including the number of years you have been practicing in your specialty. If applicable, include details of any advanced certifications or subspecialties.
    - **Location of Practice** – Include the name of the clinic, hospital, or facility you will be employed at.
    - **Additional Information** - Feel free to include any other relevant details that will support your application. This could include:
        - Your motivation for practicing in Guam (e.g., community needs, personal connection, or professional opportunities).
        - Previous experience or visits to Guam, if applicable.

GUAM BOARD OF MEDICAL EXAMINERS

CHECKLIST FOR LIMITED MEDICAL LICENSURE
(Physicians in Graduate Training)

Name: _____ **Date of Application:** _____

Medical School: _____ **State:** _____

_____ Guam Board of Medical Examiners form 3 **(GBME-3)** 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 11 **(GBME-11)** for interview questionnaire.

_____ Guam Board of Medical Examiners Form 21 **(GBME-21)** for release of information.

_____ Sponsorship Letter from a currently licensed Physician/Clinic.

_____ Verification from Institution

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

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

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

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Department of Public Health & Social Services
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ATTACH 2x2 PHOTO HERE

APPLICATION FOR LIMITED MEDICAL LICENSURE

A. IDENTIFICATION:

NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NO.: _____ PLACE OF BIRTH: _____

EMAIL ADDRESS: _____ CONTACT NO.: _____

NPI: _____ DEA: _____

MAILING ADDRESS: _____

_____

PRIMARY PRACTICE NAME AND ADDRESS: _____

_____

TELEMEDICINE: ☐ YES ☐ NO
(Please provide the name and address of the clinic or hospital where you are providing telemedicine services.)

_____

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 fellowship)**			

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 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 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: _____

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: _____ License #: _____

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:

GBME-7

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 ever 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 Narcotics Law, 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?	☐	☐	
10.	Have you ever had a liability judgments(s) or/and legal settlement(s)?	☐	☐	
11.	Have you ever changed your practice specialty?	☐	☐	

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INITIAL APPLICATION INTERVIEW QUESTIONNAIRE

(PAGE 2 OF 2)

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:	☐	☐	
15.	Are you a citizen of the United States? If "NO" you must provide proof that you will lawfully be in the United States or a jurisdiction thereof for the purpose of practicing medicine.	☐	☐	

Under penalty of perjury, any misrepresentation to the Guam Board of Medical Examiners can constitute ground 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