Department of Public Health & Social Services

GUAM BOARD OF NURSE EXAMINERS

Physical/Mailing Address:194 Hernan Cortez Avenue, Suite 213 Hagatna, GU 96910-5052
1 (671) 735-7409/4/5/7/8/10/11/12

# LICENSE APPLICATION

Please check √ appropriate ☐

☐ EXAM ☐ Re-EXAM ☐ ENDORSEMENT ☐ REINSTATEMENT, LICENSE NO. _____

☐ CNA ☐ LPN ☐ RN ☐ APRN-Specialty: _____ ☐ Prescriptive Authority

## PART I: APPLICANT INFORMATION

Complete ALL sections on the application form. You must notify the Guam Board of Nurse Examiners, in writing, of any address change(s) after you submit this application in order to receive any further notice.

| LAST NAME | FIRST NAME | MIDDLE NAME | Suffix | Social Security Number |
|---|---|---|---|---|
| | | | | |

Mailing Address:

Residence Address: (How long resided at this address?) _____

Most recent Employer(s): (List name, address, telephone)

Position Title and Employment Dates:

List names used other than stated above (maiden name, surname, aliases, etc.) and reason for change of name:

| Place of Birth (address, city, state, country) | Date of birth: (month/day/year) | ☐ Male ☐ Female |
|---|---|---|
| | | |

| Telephone Number: | Home Phone: _____<br>Work Phone: _____<br>Cell Phone: _____ | Email Address: (Print clearly) |
|---|---|---|

Emergency Contact: _____ Telephone No: _____
(Last Name, First Name M.I.) Relationship

1. Citizenship

a. Are you a United States Citizen? ☐ YES ☐ NO

b. If you answered NO to question "a" above are you:

☐ A qualified alien (as defined in 8 U.S.C.A. §1641)
☐ A non-immigrant under the Immigration and Nationality Act (8 U.S.C.A. §1101 et seq)
☐ An alien who is paroled into the United States under § 1182(d)(5) for less than one year.
☐ A foreign national not physically present in the United States.
☐ Other - Please provide detailed explanation.

c. Do you intend to seek entry into the United States for the purpose of performing labor as a healthcare worker, other than a physician? mark √ one selection ☐ ☐ YES ☐ NO

| PRINT FULL NAME | APPLICANT'S SIGNATURE | DATE |
|---|---|---|
| | | |

## PART II: EDUCATIONAL INFORMATION

| 1. Name of Last Secondary School Attended: (High School) | 2. Last Secondary School location (City and State/Jurisdiction) | 3. Date of Graduation:<br>Or Date GED Earned: (Month/Year)<br>Jurisdiction where earned: |
|---|---|---|

4. Post Secondary Education History: Starting with your undergraduate education, list all schools, colleges, and universities attended, whether completed or not, in chronological order. Use additional sheets if necessary.

| College or University Name | Location (City and State of Country) | Date of Attendance | | Graduated? Yes or No If No, give number of credit hours earned | Degree Earned/Major |
|---|---|---|---|---|---|
| | | From<br>MM/DD/YYYY | To<br>MM/DD/YYYY | | |
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5.Specialized Training:
List in chronological order from date of graduation to the present all professional post-graduate training not including continuing education coursework (i.e. residency, vocational training, practical of clinical training).

| Institutional Name | Location (City and State or Country) | Dates of Attendance | | Did you Complete Training? (mark √ one) |
|---|---|---|---|---|
| | | From<br>MM/DD/YYYY | To<br>MM/DD/YYYY | |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

1. Special Certification:
Have you earned specialized certification? (mark √ selection) ☐ Yes ☐ No

If yes, what type_____ and certification number _____

| PRINT FULL NAME | APPLICANT'S SIGNATURE | DATE |
|---|---|---|

## PART III: LICENSURE INFORMATION

If you have ever been licensed, certified or registered to practice in the profession for which you are now making application, or held any other professional license, certification or registration complete the information requested below. You must identify the method by which you obtained your professional license(s), i.e. (**1**) Licensure by examination, (**2**) Score transfer, (**3**) Endorsement, (**4**) Grandfather/waiver provision, or (**5**) Reciprocity – in the appropriate column. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. You must include jurisdictions both within and outside the United States. Failure to disclose all licenses, certifications or registrations held my result in denial of your application or other appropriate action.

| Jurisdiction | Jurisdiction/ Title of License | License Number/Name on License | How license Obtained(list applicable number from above) | Date of original initial issuance | If License is not current and in good standing, explain below or on a separate sheet |
|---|---|---|---|---|---|
| Jurisdiction of Original (Initial) Licensure | | | | | |
| Jurisdiction of Current Licensure where you most recently have been practicing: | | | | | |
| Other Jurisdictions of licensure: | | | | | |
| | | | | | |
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| | | | | | |

## PART IV: Record of Licensure Examination

If you have ever taken a licensure examination, in any state or territory of the United States, for the profession for which you are now making application, you must complete the information requested below. Each examination attempt may result in the denial of your application or other appropriate action. Use additional sheets if necessary.

| Name of Examination Note: If an examination is administered in parts, each part should be listed separately | Jurisdiction | Date of Examination | Passed/Failed/ Other (If Other, please explain) |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |

| PRINT FULL NAME | APPLICANT'S SIGNATURE | DATE |
|---|---|---|

## PART V: PERSONAL PRACTICE HISTORY INFORMATION

Please answer each of the following questions by putting a check √ in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. All "Yes" responses MUST be explained in detail in a separate paper signed and dated. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action. Make selections by marking √ in one ☐ of the following:

| | |
|---|---|
| 1. Have you ever had any application for any certification or professional license refused or denied by any licensing authority? | ☐ Yes ☐ No |
| 2. Have you ever been refused or denied the privilege of taking an examination required for any certification or professional licensure? | ☐ Yes ☐ No |
| 3. Have you ever been dropped, suspended, placed on probation, expelled, fined or requested to resign from any post secondary educational program in which you were enrolled? | ☐ Yes ☐ No |
| 4. Have you ever been placed on probation, restrictions, suspension, revocation, modification, allowed to resign, requested to leave temporarily or permanently, or otherwise acted against by any certification or professional training program prior to completing the training? | ☐ Yes ☐ No |
| 5. Have you ever voluntarily surrendered your certificate or license? | ☐ Yes ☐ No |
| 6. Have you ever allowed a limited license to lapse, issued by any other licensing authority? | ☐ Yes ☐ No |
| 7. Have you ever voluntarily surrendered any other certification or professional license? | ☐ Yes ☐ No |
| 8. Have you ever allowed any certification or professional license to lapse? | ☐ Yes ☐ No |
| 9. Has your certification or professional license ever been revoked? | ☐ Yes ☐ No |
| 10. Have you ever been the subject of disciplinary action with regard to your certification or professional license, been sanctioned by any licensing authority, association, licensed facility, or staff of such facility? | ☐ Yes ☐ No |
| 11. Has your privileges ever been restricted or terminated by any licensing authority, association, licensed facility, or staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measure? | ☐ Yes ☐ No |
| 12. Have you ever had any other certification or professional license revoked? | ☐ Yes ☐ No |
| 13. Have you ever been the subject of disciplinary action by any licensing agency with regard to any other professional license? | ☐ Yes ☐ No |
| 14. To your acknowledgment, have any unresolved or pending complaints ever been filed against you with any licensing agency, association, licensed hospital/clinic, or staff of such hospital or clinic? | ☐ Yes ☐ No |
| 15. Have you ever had a registration issued by a controlled substance authority revoked, suspended surrendered, limited, or restricted? | ☐ Yes ☐ No |
| 16. Have you ever voluntarily surrendered a registration issued by a controlled substance authority? | ☐ Yes ☐ No |
| 17. Has your application for accreditation, recertification ever been denied? (i.e. DEA) | ☐ Yes ☐ No |
| 18. Is there any disciplinary action pending against you by any licensing jurisdiction, the USDA, US Drug Enforcement Agency, or any state drug enforcement authority? If YES, where and when? | ☐ Yes ☐ No |
| 19. Have you ever been charged with or convicted (including nolo contendere plea or guilty plea) of a felony (or criminal offense) in any state or in federal court (other than minor traffic violations) whether or not a sentence was imposed or suspended? If YES, attach a certified copy of the court records regarding the conviction, the nature of the offense date of discharge, if applicable, as well as a statement from the probation or parole officer. | ☐ Yes ☐ No |
| 20. Have you ever been pardoned from a felony (or criminal) conviction? | ☐ Yes ☐ No |
| 21. Have you ever had a record expunged from a felony (or criminal) conviction? | ☐ Yes ☐ No |
| 22. Are you now or have you in the past five (5) years been addicted to any chemical substance including alcohol? (exclude tobacco and caffeine) | ☐ Yes ☐ No |
| 23. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, including any disease(s) considered chronic by the medical community, i.e.:1. Mental or emotional disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in practice as a CNA, LPN, RN, APRN? | ☐ Yes ☐ No |
| 24. Have you ever been named as a defendant to a civil suit related to your profession (i.e. malpractice)? | ☐ Yes ☐ No |
| 25. Have you ever been court marshaled or discharged other than honorably discharged from the armed forces? | ☐ Yes ☐ No |
| 26. Have you been terminated from a position with a city, county, state, or federal position? | ☐ Yes ☐ No |

IF THIS IS A RENEWAL APPLICATION, PLEASE ANSWER THE FOLLOWING ADDITIONAL QUESTIONS:
You must check √ one O of the following:

| | | |
|---|---|---|
| 27. Since the date of your last application for renewal of your license, have you been addicted to or used in excess any drug or chemical substance including alcohol? | Yes | No |
| 28. Since the date of your last application for renewal of your license, have you been treated for a drug or alcohol addiction or participated in a rehabilitation program? | Yes | No |
| 29. Since the date of your last application for renewal of your license, have you had any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, including any disease(s) considered chronic by the medical community, i.e. :1. Mental or emotional disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in practice as a CNA, LPN, RN, APRN? | Yes | No |
| 30. Within the last two (2) years have you had a license or certification revoked or suspended, other disciplinary action taken, or an application for licensure or certification refused, revoked or suspended by any professional licensing authority of another state, territory, or country? | Yes | No |

PART VI: Child Support/Spousal Support or Alimony/Educational Loan Information:

In accordance with Child Support Public Law: application for renewal of a license, endorsement or a license shall include the applicant's Social Security number, and the applicant/licensee shall certify, under penalty of perjury, that he or she is not more 90 days delinquent in complying with a child support order, order for spousal support or alimony or educational loan repayment obligation. Failure to certify may result in a disciplinary action, and making a false statement may subject the licensee to contempt of court.

Make selections with √ in ☐

☐ I am not more than 90 days delinquent in complying with: Please mark all that apply
- ☐ a) child support order
- ☐ b) order for spousal support
- ☐ c) alimony
- ☐ d) educational loan repayment obligation.

☐ I am more than 90 days delinquent in complying with a child support order/order for spousal support or spousal support or alimony/educational loan repayment obligation. Please mark all that apply
- ☐ a) child support order
- ☐ b) order for spousal support
- ☐ c) alimony
- ☐ d) educational loan repayment obligation.

☐ I am not currently under any child support order/order for spousal support or alimony/educational loan repayment obligation.

| PRINT FULL NAME | APPLICANT'S SIGNATURE | DATE |
|---|---|---|
| | | |

PART VII: CERTIFYING STATEMENT

"By virtue of filing this Guam Board of Nurse Examiners License Application, I do solemnly swear or affirm that I am of good moral character, and that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge, and that the photograph attached hereto is a true likeness of myself.

I hereby authorize the Guam Board of Nurse Examiners to verify any and all information contained in this application, including information maintained in applicable data banks, and transmit this information to the Guam Board of Nurse Examiners.

I authorize the *Guam Board of Nurse Examiners* to review files pertaining to my licensure and practices, and all law enforcement records, administrative records, motor vehicle records, and court documents to confirm the accuracy and completeness of the information provide herein.

This application and signature shall act as authorization of entities in possession of applicable information to release such information to the Guam Board of Nurse Examiners."

Date

Name of Applicant (Print)

Signature of Applicant

Subscribed and sworn to me this_____day of_____, 20_____.

*( Official Embossed Seal )*

Notary Public

**GUAM BOARD OF NURSE EXAMINERS**
Department of Public Health & Social Services
Health Professional Licensing Office
194 Hernan Cortez Avenue, Suite 213
Hagatna, GU 96910-5052

## RECORD OF PAYMENT

**I. IDENTIFICATION**

NAME: _____
(LAST) (FIRST) (MIDDLE)

MAILING ADDRESS: _____
(STREET OR P.O. BOX #)

_____
(CITY) (STATE) (ZIP CODE)

SIGNATURE: _____ DATE: _____

**II. VERIFICATION OF CERTIFICATE**

Please print the complete name used on original certification and your social security number

_____ **SOCIAL SECURITY NO.** _____
Full Name (Print) **Guam License No.** _____

III. FEE

All Fees paid are **NON-REFUNDABLE**. All checks, money orders, cashier's checks MUST BE MADE PAYABLE to **"TREASURER OF GUAM"**.
**PLEASE CHECK √ YOUR REQUEST(S)**

$100.00 ☐ RN EXAM
$100.00 ☐ PN EXAM
$100.00 ☐ Endorsement
$125.00 ☐ Reinstatement
$ 80.00 ☐ RN License Renewal
$ 60.00 ☐ LPN License Renewal
$ 25.00 ☐ License Verification

$ 150.00 ☐ RN or PN Continuation of Full Approval Fee
$ 150.00 ☐ APRN License Application Fee
$ 150.00 ☐ APRN Reinstatement of License
$ 100.00 ☐ APRN License Renewal
$ 75.00 ☐ APRN Temporary Work Permit
$ 150.00 ☐ APRN Prescriptive Authority

**NURSE ASSISTANT**

$ 50.00 ☐ Nurse Assistant Application for Exam
$ 25.00 ☐ Nurse Assistant Endorsement
$ 40.00 ☐ Nurse Assistant Reinstatement
$ 25.00 ☐ Nurse Assistant Certificate Renewal
$ 25.00 ☐ Certification Verification
$ 20.00 ☐ Reissuance of Certificate
$ 200.00 ☐ Nurse Assistant Program Approval Fee

$ 25.00 ☐ Temporary Work Permit (RN, LPN, CNA)
$ 20.00 ☐ Reissuance of License
$400.00 ☐ RN or PN Nursing Education Program Approval Fee

OTHER:
$ 35.00 ☐ Examination Proctoring
$ 10.00 ☐ Nurse Practice Act
$ 10.00 ☐ Rules and Regulations

**Present this form with your payments at any "TREASURER OF GUAM" locations and return the processed form with receipt(s) to the Board office (GBNE). OFF-ISLAND APPLICANTS: Send this form with your check(s) to GBNE at the above address.**

**FOR OFFICIAL USE ONLY**

PAYMENT: ☐ CHECK ☐ MONEY ORDER ☐ CASH ☐ CREDIT CARD

Field Receipt # _____ Date Paid: _____ Staff's Initial: _____

***DEPOSIT TO ACCOUNT: DPH 324156344***

**DO NOT MAKE PAYMENT WITHOUT A U.S. SOCIAL SECURITY NUMBER**

(R-1/14)

**GUAM BOARD OF NURSE EXAMINERS**
Health Professional Licensing Office
Department of Public Health & Social Services
194 Hernan Cortez Avenue, Suite 213
Hagatna, Guam 96910-5052
(671) 735-7409

# CERTIFICATE OF NURSING EDUCATION

**The applicant below is applying for licensure by examination to practice nursing in Guam. Please complete the following information and MUST BE SENT DIRECTLY from School of Nursing to the Guam Board of Nurse Examiners at the address provided above. Official transcripts must be attached.**

**PART A: TO BE COMPLETED BY APPLICANT**

1) **CURRENT NAME:** _____
**(Last) (First) (Middle)**

2) **PREVIOUS NAME USED:** _____
**(Last) (First) (Middle)**

**I HEREBY AUTHORIZE RELEASE OF A COPY OF MY ACADEMIC RECORDS TO THE GUAM BOARD OF NURSE EXAMINERS**

_____ _____
**Applicant's Signature** **Date**

**PART B: TO BE COMPLETED BY THE NURSING SCHOOL ADMINISTRATOR:**

1) **NAME OF APPLICANT:** _____
**(Last) (First) (Middle)**

2) **SCHOOL OF NURSING:** _____
**(Name of Nursing Program)**
**Complete Address:** _____

_____
**(City) (State/Country) (Zip/ Country Code)**

3) **Was the school Board-Approved during the applicant's enrollment?** ○ **Yes** ○ **No**

**If Yes, accredited or approved by whom:** _____

4) **Was applicant a graduate from high school or its equivalent?** ○ **Yes** ○ **No**

5) **The applicant entered the nursing education program on:** _____
**(Date)**
**and completed the** _____ **months program on** _____
**(Length) (Date)**

6) **Number of Theory Hours:** _____ **Number of Clinical Hours:** _____

7) **Attached is the OFFICIAL copy of applicant's transcripts.**

**Seal of School**

**Authorized Signature:** _____
**Print Name:** _____
**Position Title:** _____
**Date:** _____

**[ATTACHMENT A]**

# GUAM BOARD OF NURSE EXAMINERS

Health Professional Licensing Office
Department of Public Health & Social Services
194 Hernan Cortez Avenue, Suite 213
Hagatna, Guam 96910-5052

(671) 735-7409

## VERIFICATION OF LICENSE

PART I: To be completed by the applicant and forwarded to original state Board of licensure and all appropriate licensing boards. License verification form must be received directly from the State Board of Nursing to Guam Board of Nursing.

ON-LINE LICENSE VERIFICATION IS ACCEPTED ONLY WITH www.NurSys.com (attach online payment receipt)

| | | | |
|---|---|---|---|
| Name: (Last, First, Middle/Maiden) | | Previous Name(s) | |
| Current Street Address: | | City, State, Zip Code | |
| Date of Birth: (MM/DD/YY) | Social Security Number | Current License Number: Type RN ☐ LPN/VN ☐ | State |
| Name as it appears on original license (Last, First, Middle/Maiden) | | Original State of Licensure: | |
| Original License Number ☐ RN ☐ LPN/VN | | Date Issued: | |
| Nursing Education Program Completed: | | Location (City/State) | Graduation Date: |

LIST OF ALL OTHER STATES OF LICENSURE

State:_____ Lic. No:_____ Date Issued:_____

State:_____ Lic. No:_____ Date Issued:_____

State:_____ Lic. No:_____ Date Issued:_____

State: Lic. No: Date Issued:

I hereby authorize all identified Boards of Nursing to release my license data to the_____Board of Nursing.

Signature: _____

Date: _____

PART II: To be completed by licensing board and forwarded to Board of Nursing listed at the top of this form.

This is to certify that the above named individual was issued license number_____ Date Issued_____ to practice:

☐ RN ☐ LPN/Vocational Nurse

Licensed by:
- ☐ Examination
- ☐ Endorsement
- ☐ Waiver

Current License Status:
- ☐ Active
- ☐ Inactive

Expiration Date:_____

Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited placed on probation)? ☐ Yes ☐ No

Disciplinary Action Pending? ☐ Yes ☐ No (Explain Yes responses on the reverse side)→→→→→→

| | | |
|---|---|---|
| Nursing Education Program Completed: Location (City/State) | Approved by State? ☐ Yes ☐ No<br>Graduation Date | Graduated From:<br>☐ High School<br>☐ High School Equivalency<br>☐ Completion of 10th Grade |

| STATE BOARD TEST POOL EXAMINATION | | | | | | LPN/VN | NCLEX RN | NCLEX LPN/VN |
|---|---|---|---|---|---|---|---|---|
| | Medical Nursing | Psychiatric Nursing | Obstetric Nursing | Surgical Nursing | Nursing of Children | | | |
| Score | | | | | | | | |
| Series/ Form # | | | | | | | | |

Number of times applicant wrote exam: Dates Exam in English? YES NO

Signature: _____

*(BOARD SEAL)*

Title: _____

State: _____ Date_____

[ATTACHMENT FORM B]

(R-6/13)

(R-1/14)

# GUAM NURSING CONTINUING EDUCATION REPORT

Please Type or Print (Use Black or Blue ink ONLY). Please attach documentation to support CE hours.

A. IDENTIFICATION: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

1. Name:_____
   Last First MI Maiden

2. Email Address:_____ Telephone:_____ Guam License No:_____

3. Current Employer:_____ Position Title: _____

B. Continuing NURSING EDUCATION RECORD:
In compliance with the Nurse Practice Act (Section 4.10) the Guam Board of Nurse Examiners will be requiring proof of 30 Contact Hours related to NURSING or HEALTH seminars/activities.

| DATE | TOPIC | ORGANIZER'S NAME | HOURS |
|---|---|---|---|
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| | | Total Number of Contact Hours Reported: | |

I understand that my application will not be accepted for processing until it has been completed in its entirety and I hereby affirm and declare that the above information is true and correct and that any fraudulent entry may be considered cause for rejection or subsequent revocation. It is also understood that the Guam Board of Nurse Examiners may conduct and audit of the registration activities reported on these forms at anytime.

_____ _____
Signature Date

[ATTACHMENT FORM C]

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) is a federal program created to support states and territories in establishing standardized volunteer registration program for disasters and public health emergencies.

The program, administered on the local level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes. By registering through ESAR-VHP, volunteers; identities, licenses, credentials, accreditations, and hospitals privileges are all verified in advance, saving valuable time in emergency situations.

Why does Guam need ESAR-VHP?

In the wake of disasters and public health emergencies, many of our nation's health professionals are eager and willing to volunteer their services. And in these times of crisis, hospitals, clinics, and temporary shelters are dependent upon the services of health professional volunteers. However, on such short notice, taking advantage of volunteers' time and capabilities presents a major challenge to hospital, public health, and emergency response officials.

For example, immediately after the attacks on September 11, 2001, tens of thousands of people traveled to ground zero in New York City to volunteer and provide medical assistance. In most cases, authorities were unable to distinguish those who were qualified from those who were not, no matter how well intentioned.

There are significant problems associated with registering and verifying the credentials of health professionals volunteers immediately following major disasters or emergencies. Specifically, hospitals and other facilities may be unable to verify basic licensing or credentialing information, including training, skills, competencies, and employment. Further, the loss of telecommunications may prevent contact with sources that provide credential or privileges information.

The goal of the ESAR-VHP program is to eliminate a number of the problems that arise when mobilizing health professional volunteers in an emergency response.

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Please indicate if you are interested in the program and would like more information about registering as a volunteer by making the box with a √:

☐ YES, I am interested to receive more information about ESAR-VHP.

☐ NO, I am not interested.

| PRINT FULL NAME | APPLICANT'S SIGNATURE | DATE |
|---|---|---|



(R-1/14)

GUAM BOARD OF NURSE EXAMINERS
Dept. of Public Health & Social Services
194 Hernan Cortez Avenue, Suite 213
Hagatna, GU 96910-5052

AUTHORIZATION FOR RELEASE OF INFORMATION

I, (PRINT NAME), hereby authorize Guam Board of Nurse Examiners Office staff to release the following documentation to Guam Memorial Hospital Agency (GMHA) which will be needed to verify the identification and clearance for the GMHA EASR-VHP Volunteers Application. The verification and background records will be attained and include the following documents:

1.) Police Clearance
2.) Superior Court Clearance
3.) Licensure
4.) Training Certificate (release the following checked items and other when specified)

☐ NRP ☐ ACLS ☐ NIMS ICS (_____)

☐ BLS ☐ PALS

☐ Other _____

_____ _____
Signature of Applicant ESAR-VHP Volunteer Date

_____ _____
Witness by HPLO/EMS Personnel: Date

Documents released to:

_____ _____
GMHA ESAR-VHP Coordinator Date

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE GMHA PLANNING DEPARTMENT AT 647-2221.