



GUAM BOARD OF EXAMINERS FOR PHARMACY

Department of Public Health & Social Services
 Government of Guam
 123 Chalan Kareta, Mangilao, GU 96913
 Tel: (671) 735-7405~12 | Fax: (671) 735-7413

CHECKLIST – PHARMACIST BY EXAMINATION

NAME OF APPLICANT:

DATE APPLICATION REC'D:

1. _____ Signed and notarized application [GBEP-21].
2. _____ One (1) 2x2 photographs taken within the last 3 months.
3. _____ Application fee [GBEP-7].
4. _____ Notarized affidavit of the applicant of a change of name, if applicable.
5. _____ Certificate of Pharmacy Education [GBEP-3]; must be completed and submitted from school directly to the Board.
6. _____ Certification of 1500 Hours of Practical Experience [GBEP-4].
7. _____ Three (3) letters of recommendation from professional acquaintances (not older than 2 years preceding date of application).
8. _____ Passing score on the Guam Jurisprudence Examination.

For Foreign Graduates

9. _____ Certificate of Foreign Pharmacy Graduate Equivalency Examination (FPGEE).
10. _____ Official Copy of FPGEE Certificate.

**** FOR BOARD USE ONLY ****

BOARD MEMBER SIGNATURE	BOARD ACTION	DATE	COMMENTS
	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED		
	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED		
	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED		



GUAM BOARD OF EXAMINERS FOR PHARMACY

Department of Public Health & Social Services
 194 Hernan Cortez Ave., Terlaje Bldg. Ste 213A Hagatna, GU, 96910

LICENSE APPLICATION FOR PHARMACIST BY EXAMINATION

A. GENERAL INFORMATION:

1. Type or print in ink.
2. All forms must be filled completely by the applicant. Application fee should be made payable to **TREASURER OF GUAM** and is non-refundable.
3. Return complete application to the Guam Board of Examiners for Pharmacy at the above address. See **RECORD OF PAYMENT** form (GBEP-7) for applicable fees and instructions.

B. IDENTIFICATION:

Legal Name: _____
(Last) (First) (Middle Initial)

Previous Name: _____
(if any) (Last) (First) (Middle Initial)

Social Security No.: _____ Gender: () M () F

Date of Birth: _____ Place of Birth: _____
(City) (State)

Email Address: _____

Permanent Address: _____

Mailing Address: _____
(Street or P.O. Box #)

(City) (State) (Zip Code)

Phone Work: _____ Home: _____ Mobile: _____ Fax: _____

C. EDUCATIONAL BACKGROUND:

EDUCATION	NAME & ADDRESS OF SCHOOL	DATE GRADUATED	DEGREE/CERTIFICATE
1. High School			
2. College/University			
3. Post Graduate Training (Residency)			

D. PROFESSIONAL INFORMATION:

1. License Information: Please list below if you have ever held a pharmacist license in any country, state or territory of the United States.

STATE/COUNTRY LICENSE	DATE ACTIVE	DATE EXPIRE	DISCIPLINARY ACTION	
			Has license ever been revoked, suspended or investigated?	
			YES (If yes, please attach explanation)	NO

2. Professional Experience: Please list below current and former professional experiences.

FROM	TO	NAME/LOCATION	TYPE OF PRACTICE	REASON FOR DISCONTINUATION

3. Professional Certification: Please list below any current certifications.

CERTIFICATION	DATE ACTIVE	DATE EXPIRE

4. Professional associations: Please list below current professional memberships.

- a. _____
- b. _____
- c. _____
- d. _____

E. GRADUATES OF FOREIGN PHARMACY SCHOOLS:

All graduates of foreign pharmacy schools shall first write and successfully pass the Foreign Pharmacy Graduate Equivalency Examination (FPGEE), an examination administered by the Foreign Pharmacy Graduate Examination Commission (FPGEC). The Board will verify this information. Please sign permission (GBEP-10).

Date Taken: _____ Score: _____

F. REQUIREMENTS:

With this application (GBEP-2), submit the following:

1. Three (3) 2" x 2" signed photo taken within the last three (3) months.
2. Verification of pharmacy education (GBEP-3).
3. Official transcript
4. Notarized copy of diploma.
5. Foreign school graduate (GBEP-10), if applicable.
6. Certification of 1500 hours practical experience (GBEP-4).

G. AFFIDAVIT:

TO BE SWORN TO BEFORE AN OFFICER AUTHORIZED TO ADMINISTER OATHS BY THE APPLICANT WHO HAS COMPLETED THIS FORM, AND IS APPLYING FOR GUAM LICENSURE.

BEING DULY SWORN, SAYS HE/SHE IS THE PERSON REFERRED TO IN THIS APPLICATION TO BECOME LICENSED TO PRACTICE PHARMACY ON GUAM, THAT THE STATEMENTS ARE TRUE IN EVERY RESPECT AND THAT HE/SHE HAS READ AND UNDERSTOOD THE AFFIDAVIT.

SUBSCRIBE AND SWORN BEFORE ME

THIS _____ DAY OF _____, 20_____

NOTARY PUBLIC: _____

MY COMMISSION EXPIRES: _____

SIGNATURE

NOTARY PUBLIC SEAL

Applicant Name Print: _____

Date: _____

Applicant Signature: _____



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CERTIFICATE OF PHARMACY EDUCATION

THE APPLICANT BELOW IS APPLYING FOR LICENSURE THROUGH EXAMINATION TO PRACTICE PHARMACY IN GUAM. PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN **DIRECTLY** TO THE GUAM BOARD OF EXAMINERS FOR PHARMACY AT THE ABOVE ADDRESS.

PART A – TO BE COMPLETED BY THE APPLICANT:

1. CURRENT NAME _____
(Last) (First) (Middle)

2. PREVIOUS NAME USED _____
(Last) (First) (Middle)

I HEREBY AUTHORIZE RELEASE OF A COPY OF MY FOREIGN PHARMACY GRADUATE EQUIVALENCY EXAMINATION (FPGEE) SCORE AND CERTIFICATE NUMBER TO THE GUAM BOARD OF EXAMINERS FOR PHARMACY.

(Signature)

(Date)

PART B – TO BE COMPLETED BY THE PHARMACY SCHOOL ADMINISTRATOR: INDICATE (X) WHERE APPLICABLE:

1. NAME OF APPLICANT _____
(Last) (First) (Middle)

2. SCHOOL OF PHARMACY: _____
(Name)

(City) (State) (Zip Code)

3. Was the school board-approved or State Regulatory Agency-approved during the applicant's enrollment? () Yes () No

4. Was the applicant a graduate from high school or its equivalent? () Yes () No

5. The applicant entered the Pharmacy education program on _____ and completed the _____ months program on _____.

6. Number of theory hours _____; Number of clinical hours: _____.

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

Signature _____

Name _____

Title _____

Date _____

Seal of School



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CERTIFICATION OF 1500 HOURS OF PRACTICAL EXPERIENCE

THE APPLICANT BELOW IS APPLYING FOR LICENSURE THROUGH EXAMINATION TO PRACTICE PHARMACY IN GUAM. PLEASE SUPPLY THE FOLLOWING AND RETURN **DIRECTLY** TO THE GUAM BOARD OF EXAMINERS FOR PHARMACY AT THE ABOVE ADDRESS.

PART A – TO BE COMPLETED BY THE APPLICANT (Please print)

1. Current Name: _____
(Last) (First) (Middle)

2. Previous Name Used: _____
(Last) (First) (Middle)

I HEREBY AUTHORIZE RELEASE OF INFORMATION TO THE GUAM BOARD OF EXAMINERS FOR PHARMACY RELATIVE TO MY COMPLIANCE OF THE 1500 HOURS PRACTICAL EXPERIENCE IN PHARMACY UNDER THE SUPERVISION OF A REGISTERED PHARMACIST.

(Signature)

(Date)

PART B – TO BE COMPLETED BY REGISTERED PHARMACIST PRECEPTOR

Name of Applicant: _____
(Last) (First) (Middle)

Name of Pharmacy: _____

Location of Pharmacy: _____

Address of Pharmacy: _____
(P.O. Box or # and Street)

(City) (State) (Country) (Zip Code)

PLEASE CONTINUE ON REVERSE SIDE

The above-named applicant worked under my supervision from _____ to _____ for a total of _____ hours. During the period of Supervision, he/she carried out the following checked items:

- a. _____ selling of drugs
- b. _____ compounding prescriptions
- c. _____ preparing pharmaceutical preparations
- d. _____ keeping records
- e. _____ making reports as required by local and federal statutes.

Said applicant carried out job responsibilities as follows:

_____ competently with minimal supervision

_____ with moderate supervision

_____ with maximum supervision

I CERTIFY THAT THE INFORMATION PROVIDED ARE TRUE UNDER THE PENALTY OF PERJURY TO THE TRUTH AND ACCURACY OF STATEMENTS, ANSWERS AND REPRESENTATION MADE IN SUPPORT OF ABOVE-NAME APPLICANT SEEKING LICENSE TO PRACTICE PHARMACY ON GUAM.

Preceptor's Complete Name (Print)

License Number

Expiration Date

SIGNATURE

DATE



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RECORD OF PAYMENT

IDENTIFICATION

Name _____
(Last) (First) (Middle)

Mailing Address _____
(Street or P.O. Box #) (City) (State) (Zip Code)

Signature _____ Date _____

VERIFICATION OF LICENSURE: *Please print the complete name used on original license and your Social Security number.*

Name _____ SS# _____

FEE: Fee paid is **NON-REFUNDABLE**. Make all checks or money orders payable to **TREASURER OF GUAM**.

Please check your request(s):

- | | | | |
|-----|--------------------------|--|----------|
| 1. | <input type="checkbox"/> | Pharmacist's Licensure Application fee (charged once) | \$100.00 |
| 2. | <input type="checkbox"/> | Pharmacist's License Renewal fee | \$60.00 |
| 3. | <input type="checkbox"/> | Temporary License fee | \$10.00 |
| 4. | <input type="checkbox"/> | Pharmacy Permit fee | \$50.00 |
| 5. | <input type="checkbox"/> | Pharmacy Permit Renewal fee | \$30.00 |
| 6. | <input type="checkbox"/> | Pharmacy Intern Application fee | \$40.00 |
| 7. | <input type="checkbox"/> | Pharmacy Intern Renewal fee | \$40.00 |
| 8. | <input type="checkbox"/> | Pharmacy Technician License fee | \$50.00 |
| 9. | <input type="checkbox"/> | Pharmacy Technician License Renewal fee | \$30.00 |
| 10. | <input type="checkbox"/> | Penalty for late renewal of Pharmacy Intern | \$40.00 |
| 11. | <input type="checkbox"/> | Miscellaneous permit fee (Wholesalers, Drug Outlets, etc.) | \$50.00 |
| 12. | <input type="checkbox"/> | Miscellaneous Permit Renewal | \$30.00 |
| 13. | <input type="checkbox"/> | Penalty for late renewal of Pharmacist's license | \$40.00 |
| 14. | <input type="checkbox"/> | Penalty for late renewal of Pharmacy license | \$40.00 |
| 15. | <input type="checkbox"/> | Photocopying of rules and regulations (per set) | \$10.00 |
| 16. | <input type="checkbox"/> | Photocopying of Public Law (Pharmacy Portion) (per set) | \$5.00 |
| 17. | <input type="checkbox"/> | Photocopying of other records (first 5 copies) | \$3.00 |
| 18. | <input type="checkbox"/> | Photocopying (each additional sheet) | \$0.50 |

Present this form with payment to cashier at Treasurer's office, then return the processed form to GBEP Office.

Off-island applicants, return this form with payment to GBEP at the above address.

OFFICE USE ONLY: Payment Check Money Order Cash Credit Card

Receipt #: _____ Date Paid: _____ Staff Initials: _____

Account #: DPH 324156346