# GUAM BOARD OF EXAMINERS FOR PHARMACY

Department of Public Health & Social Services
Government of Guam
194 Hernan Cortez Ave., Terlaje Bldg. Suite 213, Hagatna, GU 96910
Tel: (671) 735-7404~12 | 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.

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## ** FOR BOARD USE ONLY **

| BOARD MEMBER SIGNATURE | BOARD ACTION | DATE | COMMENTS |
|---|---|---|---|
| | ☐ APPROVED<br>☐ DISAPPROVED | | |
| | ☐ APPROVED<br>☐ DISAPPROVED | | |
| | ☐ APPROVED<br>☐ DISAPPROVED | | |

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## 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_____ _____
SIGNATURE

NOTARY PUBLIC: _____

MY COMMISSION EXPIRES: _____ 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 DIRECLTY 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* _____

*Seal of School*

*Title* _____

*Date* _____

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# CERTIFICATION OF 1500 HOURS OF PRACTICAL EXPERIENCE

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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.

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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)

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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 Compete 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. Online payments can made at https://guamhplo.org/gbep/pay (additional 5% convenience fee).

Please check your request(s):

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

GBEP-7 [R 12/2017]