



GUAM BOARD OF MEDICAL EXAMINERS

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

APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT 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 LICENSURE / SUMMARY OF CHECKLIST:

- Section A Application for Licensure as a Physician Assistant (GBME-26)**
- Section B 2x2 Photo**
- Section C Proof of Eligibility to work in the United States**
- Section D Record of Payment and Fee (GBME-23)**
- Section E Interview Questionnaire (GBME-11)**
- Section F Release of Information (GBME-21)**
- Section G Certificate of Education (GBME-24)**
- Section H National Commission on Certification of Physician Assistants (NCCPA)**
- Section I Verification of Licensure**
- Section J Three (3) Letters of Recommendation**
- Section K Background Check**
- Section L Collaborative Practice Agreement (GBME-27)**
- Section M Detailed Practice Plan**



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CHECKLIST FOR FILING AN APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

Section A Application for Licensure as a Physician Assistant (GBME-26)

1. 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.
2. Applications must include the following GBME forms: **GBME-11, GBME-21, GBME-22, GBME-23, GBME-24, and GBME-27.**
3. Ensure that you provide your **FULL LEGAL NAME** as it appears on your federal identification document (e.g., U.S. Passport, Permanent Resident Card, or other Federal ID) when completing this application. It is important that the name you provide on the application matches exactly with the name on all submitted documents. *(If there is any discrepancy between the name on your application and the documents provided, you must submit an explanation for the variation).*
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 Proof of Eligibility to work in the United States

1. Provide a copy of your U.S. Passport, Permanent Resident Card, or Work Visa (as applicable).

Section D Record of Payment and Fee (GBME-23)

1. Complete the entire record of payment form and submit payment of the \$125 Application Fee, \$125 License Fee & \$50 Collaborative Practice Agreement for Prescriptive Authority. All 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.



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Section E 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 F Release of Information (GBME-21)

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

Section G Certificate of Education (GBME-24)

1. **Part A** is to be completed by the applicant. Be sure to carefully read the entire form before signing.
2. **Part B** is to be completed by the academic institution in which the applicant received their education.
3. This form must be submitted with official graduate transcripts.

Section H National Commission on Certification of Physician Assistants (NCCPA)

1. Submit a copy of your certificate from the NCCPA.

Section I Verification of Licensure

1. Submit a license verification from all U.S. or foreign countries where licensed or has applied for licensure.
2. The Board will also accept an online verification printout from the State Licensing Board, provided that the document indicates whether or not any disciplinary action has been taken against the license.

Section J Three (3) Letters of Recommendation

1. Must not be older than two (2) years preceding the date of the application.
2. One (1) must be from your immediate supervisor or your most recent employer or by a practice associate, if you are in private practice.



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Section K Background Check

1. Current Police Clearance to cover all jurisdictions in which you live or are licensed.
2. Non-Resident Applicants may submit an online background check through CastleBranch. Visit <http://www.castlebranch.com/personal-background-check> and select 'Comprehensive Background Check Package (no drug test)'.

Section L Collaborative Practice Agreement (GBME-27)

Section M 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:
 - **Years of Experience** - Provide an overview of your experience, including the number of years you have been practicing. 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.

Application Submission Address:

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



GUAM BOARD OF MEDICAL EXAMINERS

CHECKLIST FOR LICENSURE AS A PHYSICIAN ASSISTANT

Name: _____ Date of Application: _____

- _____ Guam Board of Medical Examiners form 26 (**GBME-26**) application.
- _____ Photo – Signed and Dated, taken within the past six (6) months.
- _____ Proof of Eligibility to work in the United States (i.e. U.S. Passport, Permanent Resident Card, or Work Visa).
- _____ Guam Board of Medical Examiners Form 23 (**GBME-23**) 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.
- _____ Guam Board of Medical Examiners Form 24 (**GBME-24**) for certificate of education.
- _____ National Commission on Certification of Physician Assistants (NCCPA) Certificate
- _____ Verification of Licensure.
- _____ Three (3) Letters of Recommendation.
- _____ Background Check.
- _____ Guam Board of Medical Examiners Form 27 (**GBME-27**) for collaborative practice agreement.
- _____ 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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**ATTACH
2x2
PHOTO
HERE**

APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

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			
GRADUATE SCHOOL			
POST GRADUATE TRAINING (Internship/Residency)			



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C. PROFESSIONAL INFORMATION:

1. List *past* and *current* medical licenses for the United States and its Territories and Canada:

2. Professional Experience as a physician over the five (5) consecutive years:

FROM	TO	LOCATION	TYPE OF PRACTICE	REASON FOR DISCONTINUATION

3. CAQ (Certificates of Added Qualifications):

Specialty: _____ Date of Expiration: _____

Specialty: _____ Date of Expiration: _____

Specialty: _____ Date of Expiration: _____

4. Name & License No.: of Supervising Physician: _____

(NOTE: ATTACH COPY OF BOARD CERTIFICATION)

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.

Applicant Signature: _____ Date: _____

SUBSCRIBED AND SWORN TO BEFORE ME THIS
_____ DATE OF _____

NOTARY PUBLIC: _____

(NOTARY SEAL)

COMMISSION EXPIRES: _____



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CERTIFICATE OF EDUCATION

THE APPLICANT BELOW IS APPLYING FOR A LICENSE TO PRACTICE IN GUAM. PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN **DIRECTLY** TO THE GUAM BOARD OF MEDICAL EXAMINERS AT THE ADDRESS ABOVE.

PART A – TO BE COMPLETED BY THE APPLICANT:

Applicant's Full Legal Name: _____

I hereby authorize the release of a copy of my academic record to the Board.

Applicant's Signature: _____ Date: _____

PART B – TO BE COMPLETED BY THE SCHOOL ADMINISTRATOR:

1. Name of Applicant: _____

2. Name of College/University: _____

3. Address of College/University: _____

4. Was the school Board-Approved or State Regulator Agency-Approved during the Applicant's enrollment? () Yes () No

If Yes, by whom: _____

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

6. Number of Theory Hours _____; Number of Supervised Clinical/Fieldwork Hours _____.

7. Attached is the Official Copy of Applicant's Transcript.

Signature: _____

Name: _____

Title: _____

Date: _____

Seal of School



GUAM BOARD OF MEDICAL EXAMINERS

RECORD OF PAYMENT (Podiatrists & Physician Assistants Only)

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 No.: _____

Fee: Please make all check or money orders payable to *Treasurer of Guam*. Online payments may be made at www.guamhplo.org/gbme (additional 5% convenience fee). All fees are **NON-REFUNDABLE**.

Please check your request(s):

- | | | | |
|--------|-------------------------------------------------------|----|--------|
| 1. () | Application by Endorsement | \$ | 125.00 |
| 2. () | Application by Examination | \$ | 125.00 |
| 3. () | License Fee (Initial) | \$ | 125.00 |
| 4. () | Renewal Fee | \$ | 80.00 |
| 5. () | Late Renewal Penalty | \$ | 100.00 |
| 6. () | Collaborative Practice Agreement (Initial or Renewal) | \$ | 50.00 |
| 7. () | License Verification | \$ | 25.00 |

NOTE: Mail this form to the: *Guam Board of Medical Examiners, 194 Hernan Cortez Ave. Suite 213, Hagatna, GU 96913*

FOR OFFICE USE ONLY: Payment () Check () Money Order

Field Receipt No.: _____ Date Paid: _____ GBME-23



Guam Board of Medical Examiners

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Collaborative Practice Agreement for Physician Assistants

The Physician Assistant (PA) will only prescribe medicines outlined in the list below under the supervision of his or her Supervising Physician. The Supervising Physician and the PA will determine the appropriate medications to be prescribed under his or her scope of practice and submit the Collaborative Practice Agreement (CPA) to the Guam Board of Medical Examiners (GBME) and the Guam Board of Examiners for Pharmacy (GBEP).

The original CPA will be kept in the Physician Assistant's file at the Health Professional Licensing Office (HPLO).

The PA may prescribe from these categories checked in the following list:

A. Drugs:

Exceptions applicable to each category:

- | | |
|---------------------------------------------------------------------------------------|-------|
| <input type="checkbox"/> 01 Anesthetics | _____ |
| <input type="checkbox"/> 02 Anti-Infective | _____ |
| <input type="checkbox"/> 03 Anti-Neoplastics/Immunosuppresants | _____ |
| <input type="checkbox"/> 04 Cardiovascular Medications | _____ |
| <input type="checkbox"/> 05 Autonomic/CNS Drugs | _____ |
| <input type="checkbox"/> 06 Dermatologic Drugs | _____ |
| <input type="checkbox"/> 07 Diagnostic Agents | _____ |
| <input type="checkbox"/> 08 Ear-Nose-Throat Medications | _____ |
| <input type="checkbox"/> 09 Endocrine Medications | _____ |
| <input type="checkbox"/> 10 Gastrointestinal Medications | _____ |
| <input type="checkbox"/> 11 Immunologicals and Vaccines | _____ |
| <input type="checkbox"/> 12 Muskuloskeletal Medications | _____ |
| <input type="checkbox"/> 13 Nutritional Products, Electrolytes and
Blood Modifiers | _____ |
| <input type="checkbox"/> 14 OB/GYN Medications | _____ |
| <input type="checkbox"/> 15 Opthalmin Medications | _____ |
| <input type="checkbox"/> 16 Respiratory Medications | _____ |
| <input type="checkbox"/> 17 Urological Medications | _____ |
| <input type="checkbox"/> 18 Poisoning and Drug Dependence | _____ |
| <input type="checkbox"/> 19 Analgesics | _____ |
| <input type="checkbox"/> 20 Stimulants | _____ |
| <input type="checkbox"/> 21 Tranquillizers | _____ |



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APPLICATION TO SUPERVISE A PHYSICIAN ASSISTANT

GENERAL INFORMATION

1. Name of Physician: _____
 (Last Name) (First Name) (Middle)
2. Mailing Address: _____
 (Street or PO Box #) (City) (State) (Zip Code)
3. Phone Number: _____ (Office) _____ (Cell) 4. Guam Medical License Number: _____
5. Indicate Residency Training Completed: _____
 (Where) (Specialty) (Date)
6. Have you ever applied for approval to supervise a Physician Assistant? Yes _____ No _____
 If answer is "Yes", give name(s), type(s), date(s), location(s) and details. _____

7. Is this application being submitted in conjunction with another physician's application to supervise said Physician Assistant?
 Yes _____ No _____
 If "Yes", list names of other physicians who will supervise the same Physician Assistant: _____

8. Who will be your Physician Assistant? _____

GENERAL INFORMATION

1. Type (e.g., Family, Industrial, etc.) and Specialty: _____
 If Family Practice, indicate percentage of time spent in the following:
 Surgery _____ Medicine _____ OB/GYN _____ Pediatrics _____ Other _____
2. Are you Board Certified? Yes _____ No _____ Date of Certification _____
 Indicate which Board specialty _____ Are you Board Eligible? Yes _____ No _____
3. Indicate: Solo Practice _____ Group Practice _____ Number in Group _____
4. Name of Group _____ Single-Specialty _____ Multi-Specialty _____
5. Have you ever had your hospital staff privileges denied, suspended, revoked? Yes _____ No _____
 If yes, explain: _____

6. Have you ever had any medical license suspended, revoked, or otherwise disciplined? Yes _____ No _____
 If yes, explain: _____

USE AND NEEDS PROJECTIONS

1. Describe fully how you propose to utilize a Physician Assistant, i.e., duties to be performed by the Physician Assistant.

2. Protocols and specific plans for supervision of the Physician Assistant, i.e., frequency of the chart review, availability for immediate in-person consultation, situations beyond ability and scope of Physician Assistant.

3. Protocol for patients examined by a Physician Assistant and who require prescription medicine. _____

4. Type of health care facility in which the Physician Assistant will be functioning _____

5. Physician's relationship to facility(ies) _____

I have read and fully understand the Physician Assistant Regulations promulgated by the Guam Board of Allied Health Examiners and apply for approval to supervise a Physician Assistant in the Territory of Guam in accordance with those laws and state under penalty of perjury under the laws of the Territory of Guam that I am the person whose signature is affixed below and that all statements made are true in every respect, and understand that mis-statements or omissions of material facts may be cause for denial of this application or revocation of any approval granted.

 Signature of Physician

 Date

All information is mandatory. Failure to provide any of the mandatory information will result in the application being rejected as incomplete. Each individual has the right to review his/her file maintained by the agency, subject to the provisions of the Information Practices Act.



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B. Controlled Substances:

- Schedule II (not applicable) Schedule IV
 Schedule III (not applicable) Schedule V

Identification:

	DEA Certificate Number
Name of Physician Assistant (Print & Signature)	DEA Certificate Number
Name of Supervising Physician (Print & Signature)	

Practice Sites:

Name of Primary Practice Site on Guam	Practice Setting
Location Address: _____	
(Street)	(City) (State) (Zipcode)

Name of Secondary Practice Site on Guam	Practice Setting
Location Address: _____	
(Street)	(City) (State) (Zipcode)

I, _____, Physician Assistant, and
 _____, MD/DO, the Supervising
 Physician, agree to the following scope of practice:

The Physician Assistant (PA) working in this practice will provide medical services within the education, training and experience of the PA that are delegated by and within the scope of practice of the Supervising Physician. These services include but are not limited to: histories and physical examinations (surface, oral, rectal and pelvic); ordering and/or performing diagnostic and therapeutic procedures; formulating a working diagnosis; developing and implementing a treatment plan; prescribing medications and other treatment modalities; monitoring the effectiveness of therapeutic interventions; assisting at surgery; performing minor surgical procedures including wound treatments, skin and soft tissue debridements, closures, biopsies, incision and drainage of abscesses; splinting and casting of minor fractures; offering counseling and education to meet patient needs; and making appropriate referrals. The PA will work under indirect supervision with a high degree of independence and will confer with the Supervising Physician when necessary to determine appropriate diagnosis, treatment or referral.



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- | <u>C. Procedures Performed by the Physician Assistant:</u> | <u>Exceptions applicable to each category:</u> |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Administration of local and digital anesthesia | _____ |
| <input type="checkbox"/> Complicated laceration repair to include suturing, stapling and adhesives | _____ |
| <input type="checkbox"/> Uncomplicated laceration repair to include suturing, stapling and adhesives | _____ |
| <input type="checkbox"/> Removal of foreign bodies from eyes, nose, skin and wounds | _____ |
| <input type="checkbox"/> Minor surgical procedures, such as skin biopsies, mole, cyst and wart removals | _____ |
| <input type="checkbox"/> Drainage of subungual hematomas | _____ |
| <input type="checkbox"/> Incision and drainage of abscesses | _____ |
| <input type="checkbox"/> Urethral catheterization | _____ |
| <input type="checkbox"/> Pelvic examination, diagnostic and therapeutic | _____ |
| <input type="checkbox"/> Placement of peripheral venous access | _____ |
| <input type="checkbox"/> Placement of intraosseous route | _____ |
| <input type="checkbox"/> Endotracheal intubation | _____ |
| <input type="checkbox"/> Advanced cardiac life support procedures | _____ |
| <input type="checkbox"/> Venipuncture | _____ |
| <input type="checkbox"/> Application of splints and casts | _____ |
| <input type="checkbox"/> Arthrocentesis | _____ |
| <input type="checkbox"/> Reduction of closed dislocations | _____ |

Name of Physician Assistant (Print & Signature)

Date

Name of Supervising Physician (Print & Signature)

Date



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SUPERVISING PHYSICIAN FORM

FOR

PHYSICIAN ASSISTANT

Physician Assistant's Name: _____

Physician Assistant's Address: _____
(Street or PO Box #)

(City)

(State)

(Zip Code)

Supervising Physician	Specialty	Signature

Statement from Supervising Physician specifying specialty areas in which the Physician Assistant should provide services:
