GUAM BOARD OF MEDICAL EXAMINERS

Applicant to send to hospital/organization and is responsible for all fees and charges.

My signature below is your authority to release any and all information in your files favorable or otherwise regarding myself, directly to:

Department of Public Health & Social Services
Health Professional License Office
1 + H U Q Signature Q &
+ Guam 9691 J D W Q D,

HOSPITAL VERIFICATION / PRACTICE VERIFICATION

Applicant's Name: _____

Date of Birth: _____

Hospital: _____

Address: _____

Position(s) Held: _____

Committees, Department: _____

Was there any adverse information occurrence during hospital affiliation?:

_____

_____

_____

Name of Verifier: _____
(Print)

Title: _____

Signature: _____

Date: _____

SEAL

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