



GUAM BOARD OF NURSE EXAMINERS
Department of Public Health & Social Services



NURSING RENEWAL APPLICATION FORM

CNA LPN RN APRN

Personal Data		
Last Name	First Name	Middle
Social Security Number:		
Guam Board of Nurse Examiners License Number:		
Date of Birth:	Place of Birth:	
Previous Name(s):		
Mailing Address:		
Residential Address:		
Telephone Number(s):		
Email Address:		
Professional Data		
Highest Nursing Degree Obtained:	Date Obtained:	
Highest Educational Degree:	Date Obtained:	
Specialty or Certification in Nursing:	Number of Years:	
Employment History		
Current Employer:	Address:	Telephone Number:
Position Title/Section:		

Disciplinary History	
Have any licenses been restricted, revoked, suspended, surrendered or denied?	() Yes () No
Have you been disciplined or a subject in any disciplinary hearings?	() Yes () No
Have you ever resigned or been told to resign from employment to avoid termination?	() Yes () No
Were you terminated from employment for any reason?	() Yes () No
Any pending complaints, charges against you as related to nursing practice?	() Yes () No
History of Drugs or Alcohol Misuse/Abuse/Addictions/Treatments?	() Yes () No
Any Criminal Court convictions?	() Yes () No
Any allegations of unprofessional unethical conduct?	() Yes () No
I am the subject of a medical malpractice liability claim, settlement, judicial or administrative adjudication case pending or otherwise resolved.	() Yes () No
Have you been fined for any reason for nursing practice violation?	() Yes () No
History of fraud in the procurement of a license or certification?	() Yes () No
History of Sexual Crime(s) or are you listed on the Sexual Registry?	() Yes () No
History or Present Physical, Mental, Emotional, Behavioral Conditions that may affect nursing practice?	() Yes () No
I am delinquent or more than 90 days in child support, spousal support/alimony or payment of an educational loan.	() Yes () No
*Supporting Documents and Statements must accompany all "Yes" answers.	

<p><i>Certifying Statement:</i></p> <p><i>I certify all information submitted in this application is true and complete to the best of my knowledge and belief and I have the ability to perform within my scope of practice. By virtue of signing this application, I do solemnly swear that I am of good character, free of communicable disease, in good physical and mental health, and I personally completed this form, and the photo is my true likeness.</i></p> <p><i>I authorize the Guam Board of Nurse Examiners, the Health Professional Licensing Office (DPHSS) staff, and their agents to investigate, verify, obtain, release, any and all information provided through personnel files, legal documents, emails, and other forms of communication-written or verbal.</i></p> <p><i>I authorize the release of professional and personal information to individuals, institutions, agencies, and the Data Bank.</i></p> <p><i>I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional competence, personal health, character, ethics, and other qualifications for resolving any doubts of such qualifications.</i></p> <p><i>I understand that knowingly providing false or incomplete information is punishable by fine or imprisonment under United States Code Title 18, Section 1001 and all applicable laws of Guam. If I am a non US Citizen, I will provide supporting documentation showing eligibility to work and lice in the United States and in the Territory of Guam.</i></p> <p><i>Print Name:</i></p> <p><i>Signature:</i></p> <p><i>Date:</i></p>
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Subscribed and sworn to me this _____ day of _____, in this year _____

Notary Public _____

Expiration Date _____

Address/Telephone Number _____

(Affix Seal Here)

GUAM BOARD OF NURSE EXAMINERS
 Department of Public Health & Social Services

GUAM NURSING CONTINUING EDUCATION REPORT

Please Type or Print (Use Blue or Black Ink ONLY)

A. IDENTIFICATION: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.			
1. Name: _____ Guam Certificate No. _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Last First MI </div>			
2. Email Address: _____ Telephone No.: _____			
3. Current Employer: _____ Position Title: _____			
B. CONTINUING NURSING EDUCATION RECORD:			
DATE	TOPIC	ORGANIZER'S NAME	HOURS
Total Number of Hours Reports:			
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 an audit of the registration activities reported on these forms at anytime.			
_____ Signature		_____ Date	



Department of Public Health & Social Services
GUAM BOARD OF NURSE EXAMINERS



RECORD OF PAYMENT

I. IDENTIFICATION

NAME: _____
 (Last Name) (First Name) (Middle)

MAILING ADDRESS: _____
 (Street Address)

 (City) (State) (Zip Code)

SIGNATURE: _____ DATE: _____

II. VERIFICATION OF CERTIFICATE:

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

_____ SS# _____
 (Print Full Name)

SIGNATURE: _____ DATE: _____

III. FEE

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

\$ 100.00	RN EXAM	\$ 150.00	RN/LPN Continuation of Full Approval Fee	\$ 50.00	Nurse Assistant Application for Exam
\$ 100.00	LPN EXAM	\$ 150.00	APRN License Application Fee	\$ 25.00	Nurse Assistant Endorsement
\$ 100.00	RN/LPN Endorsement	\$ 150.00	APRN Reinstatement of License	\$ 40.00	Nurse Assistant Reinstatement
\$ 125.00	RN/LPN Reinstatement for Lapsed or Inactive	\$ 100.00	APRN License Renewal	\$ 25.00	Nurse Assistant Certificate Renewal
\$ 80.00	RN License Renewal	\$ 75.00	APRN Temporary Work Permit	\$ 25.00	Certification Verification
\$ 60.00	LPN License Renewal	\$ 150.00	APRN Prescriptive Authority	\$ 20.00	Reissuance of Certificate
\$ 25.00	License Verification		OTHER	\$ 200.00	Nurse Assistant Program Approval Fee
\$ 25.00	RN/LPN/CNATemporary Work Permit	\$ 35.00	Examination Proctoring		
\$ 20.00	RN/LPN Reissuance of License	\$ 10.00	Nurse Practice Act		
\$ 400.00	RN/PN Nursing Education Program Approval Fee	\$ 10.00	Rules and Regulations		

Present this form with payment to the cashier at the Department of Public Health & Social Services/Treasurer's Office then return the processed form to GBNE.

OFF-ISLAND APPLICANTS: Return this form with your payment to the GBNE at the above address.

FOR OFFICE USE ONLY			
Payment:	CHECK	MONEY ORDER	CASH CREDIT CARD
Field Receipt#:	_____		Date Paid: _____
DEPOSIT TO ACCOUNT: 324156344			

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.

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

GUAM BOARD OF NURSE EXAMINERS

Department of Public Health & Social Services

Physical/Mailing Address: 194 Hernan Cortez Avenue

Terlaje Professional Building, 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

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.