



# GUAM BOARD OF MEDICAL EXAMINERS

## APPLICATION CHECKLIST FOR FULL MEDICAL LICENSE

Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Specialty: \_\_\_\_\_

- \_\_\_\_\_ Guam Board of Medical Examiners form 1 (GBME-1) application.
- \_\_\_\_\_ Photo – Signed and Dated, taken within the past six (6) months.
- \_\_\_\_\_ Guam Board of Medical Examiners Form 7 (GBME-7) for record of payment.
- \_\_\_\_\_ Guam Board of Medical Examiners Form 9 (GBME-9) for CME Report. (2022, 2023, & Current)
- \_\_\_\_\_ 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.
- \_\_\_\_\_ Federation Credential Verification Service (FCVS) Medical Professional Profile for primary source verification; to be sent directly to the GBME.
- \_\_\_\_\_ Certificate of Medical Education Form (GBME-3)
- \_\_\_\_\_ Certificate of Internship/Residency Program Form (GBME-4)
- \_\_\_\_\_ Hospital/Practice Verification Form (GBME-5.0)
- \_\_\_\_\_ State Board Verification (GBME-5.2).
- \_\_\_\_\_ Qualifying Examination Certificates that you have completed in accordance to GMBE requirements for each new applicant: FLEX; NBME; USMLE; COMLEX; OTHER.
- \_\_\_\_\_ National Practitioner Data Bank self-query sent directly to GBME.
- \_\_\_\_\_ Notarized copy of ECFMG certificate for foreign medical graduates or original certificate sent directly to GBME.
- \_\_\_\_\_ American Medical Association (AMA) physician's profile sent directly to GBME.
- \_\_\_\_\_ 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.**

GBME – Checklist for Full Licensure (Rev. 3/24)



# GUAM BOARD OF MEDICAL EXAMINERS

## APPLICATION FOR INITIAL FULL MEDICAL LICENSURE

ATTACH  
2x2  
PHOTO  
HERE

### GENERAL INFORMATION AND INSTRUCTIONS

1. Please type or print.
2. Unsigned applications shall be considered incomplete and will be returned for signature.
3. Applications must include the following: **Completed checklist: GBME-1, GBME-7, GBME-9, GBME-11, GBME-21 Form, and payment.**
4. Please make all check or money orders payable to *Treasurer of Guam*. *Online payments* can be made at [www.guamhplo.org/gbme](http://www.guamhplo.org/gbme) (additional 5% convenience fee).

### A. IDENTIFICATION:

1. NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_
2. SOCIAL SECURITY NO.: \_\_\_\_\_ SEX: \_\_\_\_\_ M \_\_\_\_\_ F
3. PLACE OF BIRTH: \_\_\_\_\_ CONTACT NO.: \_\_\_\_\_
4. EMAIL ADDRESS: \_\_\_\_\_ NPI: \_\_\_\_\_
5. PRIMARY PRACTICE ADDRESS: \_\_\_\_\_  
\_\_\_\_\_
6. MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

### B. EDUCATIONAL INFORMATION:

EDUCATIONAL BACKGROUND	NAME & ADDRESS	DATE GRADUATED	DEGREE
COLLEGE/UNIVERSITY			
MEDICAL SCHOOL			
POST GRADUATE TRAINING (Only list ACGME or AOA approved internship, residency, and fellowship)			

GBME-1



# GUAM BOARD OF MEDICAL EXAMINERS

## C. PROFESSIONAL INFORMATION:

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

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2. EXAMINATIONS TAKEN (List only if passed and list all parts and dates taken if applicable):

ECFMG: \_\_\_\_\_  
 FLEX: Component 1: \_\_\_\_\_ Component 2: \_\_\_\_\_  
 NBME: Part 1: \_\_\_\_\_ Part 2: \_\_\_\_\_ Part 3: \_\_\_\_\_  
 USMLE: Part 1: \_\_\_\_\_ Part 2: \_\_\_\_\_ Part 3: \_\_\_\_\_

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

FROM	TO	LOCATION	TYPE OF PRACTICE	REASON FOR DISCONTINUATION

4. ABMS (American Board of Medical Specialties) Specialty Certification:

a. I am ABMS BOARD CERTIFIED in the following:

<u>Specialty</u>	<u>Date Issued</u>	<u>Date Expired</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**(NOTE: ATTACHED COPY OF EACH ABMS BOARD CERTIFICATION)**



# GUAM BOARD OF MEDICAL EXAMINERS

5. My area of practice is/are: \_\_\_\_\_

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## 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: \_\_\_\_\_



# GUAM BOARD OF MEDICAL EXAMINERS

## RECORD OF PAYMENT

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### I. IDENTIFICATION

Name: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

Mailing: \_\_\_\_\_  
(CITY) (STATE) (ZIP)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### II. Verification of Licensure: Please print the complete name used on original license and your Social Security Number

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

**Fee:** Please make all check or money orders payable to *Treasurer of Guam*. Online payments can be made at [www.guamhplo.org/gbme](http://www.guamhplo.org/gbme) (additional 5% convenience fee).

All fees are **NON-REFUNDABLE**.

Please check your request(s):

1. ( )	Application Fee	\$	150.00
2. ( )	License Fee	\$	250.00
3. ( )	USMLE Step 3 Examination	\$	530.00
4. ( )	Temporary License	\$	125.00
5. ( )	License Renewal	\$	250.00
6. ( )	Late Renewal Penalty Fee	\$	150.00
7. ( )	Inactive Status	\$	300.00
8. ( )	Reinstatement of License	\$	400.00
9. ( )	License Verification	\$	25.00
10. ( )	Re-Issuance (duplicate) License Certificate	\$	100.00
11. ( )	Re-Issuance (duplicate) License Card	\$	20.00
12. ( )	Physicians Practice Act	\$	10.00
13. ( )	Physicians Practice Act Admin. Rules & Regulations	\$	10.00
14. ( )	Photocopy (up to five (5) pages)	\$	4.00
15. ( )	Photocopy (each additional page)	\$	.50

### Interstate Medical Licensing Compact

1. ( )	Application Fee	\$	150.00
2. ( )	License Fee	\$	250.00
3. ( )	Letter of Qualification	\$	300.00

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

ACCOUNT #: 324156343

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

Field Receipt No.: \_\_\_\_\_ Date Paid: \_\_\_\_\_

GMBE-7



# GUAM BOARD OF MEDICAL EXAMINERS

## CME (CONTINUING MEDICAL EDUCATION) CATEGORIES

- Category I: Continuing Medical Education activities accredited by the American Medical Association and other activities approved in advance by the GBME. A minimum of 50% of the credit hours reported should be in this category.
- Category II: Continuing Medical Education Activities with non-accredited sponsorship.
- Category III: Medical teaching credit may be claimed for contact hours of teaching of medical students, interns, residents, and allied health professionals.
- Category IV: Papers, Publications, Books and Exhibits; ten (10) credit hours may be claimed for each paper published or given before a medical audience.
- Category V: Credit hours may be claimed for time spent with Self-Instruction activities (journal reading, studying medical audiovisual material), patient care review and Self-Assessment Examinations.
- Category VI: Other Meritorious Learning Experiences: These activities that do not fit into the other five (5) categories, but which the applicant feels represent valid continuing medical education. Submit a description of the activity for review by the Board.

## CME REQUIREMENTS

1. **Initial application for full licensure:**
  - a. A minimum of 100 credit hours of CME over the past two (2) years. Of this, at least 50% (50 credits) must be in Category I. (Attach copies.)
2. **Renewing a full medical license:**
  - a. A minimum of 100 credit hours of CME over the past two (2) years. Of this, at least 50% (50 credits) must be in category I. (Attach copies.)
  - b. At least two (2) credit hours of category I CME must be in Medical Ethics course(s). (Attach copies.)

**Note:** The Physician's Recognition Award obtained from the American Medical Association will be recognized as category I credits. Completion of an ACGME accredited residency or fellowship within the last year prior to application for licensure will meet the GBME CME requirements. Verification of such training must be provided to the GBME.



# GUAM BOARD OF MEDICAL EXAMINERS

## CONTINUING MEDICAL EDUCATION REPORT

### A. IDENTIFICATION

1. Name: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MAIDEN)
2. SSN.: \_\_\_\_\_ Date of birth: \_\_\_\_\_
3. Guam License No.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**B. CME CATEGORIES AND REQUIREMENTS: A minimum of 100 credit hours of CME over the past two(2) years. Of this, at least a minimum of 50 Category I credit hours relevant in the field of your practice. (SEE REVERSE PAGE)**

### C. LISTING OF CONTINUING EDUCATION PARTICIPATION: (PLEASE PRINT OR TYPE)

Course Title	Sponsored By	Dates Attended	Accredited/Approved by (AMA, AAFP, ACOG, etc.)	Category	Credit Hours

Total No. of Credit hours Reported: \_\_\_\_\_

*I certify under penalty of perjury to the truth and accuracy of all statements, answers and representations made in the foregoing.*

\_\_\_\_\_

(Signature of Physician)

\_\_\_\_\_

(Date)

**ATTACH COPIES OF ALL CATEGORY I CERTIFICATES**



# GUAM BOARD OF MEDICAL EXAMINERS

## INITIAL APPLICATION INTERVIEW QUESTIONNAIRE

PAGE 1 OF 2

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE INDICATE YES or NO and INITIAL each entry.**

*(All "YES" answers to the following questions must be accompanied by a written statement with dates explaining the circumstances that must be acceptable to the GBME)*

	YES	NO	INITIAL
1 Has your license to practice medicine ever been revoked, suspended, or restricted Or has there been any disciplinary action taken against you in any state or territory?	_____	_____	_____
2 Have you ever been convicted of any felony or misdemeanor, except for minor traffic violations under the laws of any state or territory?	_____	_____	_____
3 Has any disciplinary action ever been taken against you by a government agency, Law enforcement agency, any peer review body, healthcare institution, or professional Medical society regarding your clinical or ethical performance as a physician?	_____	_____	_____
4 Have you voluntarily surrendered your medical license while under investigation in any state or territory?	_____	_____	_____
5 Have you ever been licensed or privileged to practice medicine by a government Jurisdiction including the military, public health or foreign government.	_____	_____	_____
6 Have you ever been denied a narcotic license, charged or convicted of a violation Of a Federal, State or Territorial Narcotic Laws, or asked to surrender your narcotic license?	_____	_____	_____
7 Has your staff privileges at any hospital/healthcare institution ever been denied, reduced or removed, or have you ever been subject to disciplinary action for reasons pertaining to your clinical or ethical performance as a physician?	_____	_____	_____
8 Have you ever voluntarily resigned or limited your staff privileges at any hospital/Health care institution while under formal or informal investigation by the institution or a committee thereof?	_____	_____	_____
9 Have you ever voluntarily resigned or withdrawn from a nation state or county medical society, association or organization while under a formal or informal investigation by the institution or a committee thereof?	_____	_____	_____





# GUAM BOARD OF MEDICAL EXAMINERS

## CONTINUATION OF INITIAL APPLICATION INTERVIEW QUESTIONNAIRE PAGE 2 OF 2

	YES	NO	INITIAL
10 Have you ever had a liability judgments(s) or/and legal settlement(s)?	_____	_____	_____
11 Have you ever changed your practice specialty?	_____	_____	_____
12 Have you ever been addicted to the use of narcotics, barbiturates, alcohol or other drugs	_____	_____	_____
13 Do you presently have a physical or mental health condition that can affect or is reasonably likely to affect your ability to perform your medical duties or affect your clinical judgment?	_____	_____	_____
14 Have you ever been licensed or applied for licensure on Guam? If "YES" Please indicate date: _____	_____	_____	_____
15 Are you a citizen of the United States? If "NO" you must provide proof that you will lawfully be in the United States or a jurisdiction thereof for the purpose of practicing medicine.	_____	_____	_____

Under penalty of perjury, any misrepresentation to the Guam Board of Medical Examiners can constitute grounds for denial suspension or revocation of your medical license and prosecution to the full extent of the laws of Guam.

This form when completed must be submitted with your application for medical licensure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Signature of Reviewing Board Representative  
Guam Board of Medical Examiners

\_\_\_\_\_  
Date



# Guam Board of Medical Examiners

Applicant Full Legal Name: \_\_\_\_\_  
(First, Middle, Last, Suffix)

Date of Birth: \_\_\_\_\_  
(mm/dd/yyyy)

I, \_\_\_\_\_ being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete Guam Board of Medical Examiners' application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct, to include all previously submitted documents; and that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, licensing boards, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Guam Board of Medical Examiners or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Guam Board of Medical Examiners or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I understand that such collection of information may include physical documents, electronically transmitted documents and verbal discussion in person, via phone or electronic devices, e.g., via the internet.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)



# GUAM BOARD OF MEDICAL EXAMINERS

## CERTIFICATE OF MEDICAL EDUCATION

THE APPLICANT BELOW IS APPLYING FOR LICENSURE TO PRACTICE MEDICNE IN GUAM. PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN ***DIRECTLY TO THE BOARD AT 194 Hernan Cortez Ave., Suite 213, Hagatna, GU 96910***

### PART A — TO BE COMPLETED BY APPLICANT

1. Current Name: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)
2. Previous Name Used: \_\_\_\_\_  
(Last) (First)
3. Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I HEREBY AUTHORIZED RELEASE OF A COPY OF MY ACADEMIC RECORD TO THE GUAM BOARD OF MEDICAL EXAMINERS.**

\_\_\_\_\_  
(Signature) (Date)

### PART B — TO BE COMPLETED BY THE MEDICAL SCHOOL ADMINISTRATOR: INDICATE (X) WHERE APPLICABLE.

1. Name of Applicant: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)
2. School of Medicine: \_\_\_\_\_  
(City) (State) (Zip)
3. WAS THE SCHOOL BOARD APPROVED OR STATE REGULATORY AGENCY APPROVED DURING THE APPLICANT'S ENROLLMENT? ( ) YES ( ) NO  
 IF YES, BY WHOM: \_\_\_\_\_
4. WAS THE APPLICANT A GRADUATE FROM COLLEGE? ( ) YES ( ) NO
5. THE APPLICANT ENTERED THE MEDICAL PROGRAM ON \_\_\_\_\_ AND COMPLETED THE \_\_\_\_\_ MONTHS PROGRAM ON \_\_\_\_\_
6. **ATTACHED IS THE OFFICIAL COPY OF APPLICANT TRANSCRIPT.**

SEAL  OF  SCHOOL	SIGNATURE: _____  NAME: _____  TITLE: _____
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# GUAM BOARD OF MEDICAL EXAMINERS

## CERTIFICATE OF INTERNSHIP/RESIDENCY PROGRAM

THE APPLICANT BELOW IS APPLYING FOR LICENSURE TO PRACTICE MEDICINE IN GUAM. PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN ***DIRECTLY TO THE BOARD AT 194 Hernan Cortez Ave., Suite 213, Hagatna, GU 96910***

### PART A — TO BE COMPLETED BY APPLICANT

1. Current Name: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)
2. Previous Name Used: \_\_\_\_\_  
(Last) (First)
3. Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I HEREBY AUTHORIZED RELEASE OF A COPY OF MY ACADEMIC RECORD TO THE GUAM BOARD OF MEDICAL EXAMINERS.**

\_\_\_\_\_  
(Signature) (Date)

### PART B - TO BE COMPLETED BY THE AUTHORIZED PERSON WITHIN THE INSTITUTION.

1. Name of Applicant: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)
2. Name of Institution: \_\_\_\_\_
3. Address of Institution: \_\_\_\_\_  
(City) (State) (Zip)
4. The above named applicant started the \_\_\_\_\_ INTERNSHIP/\_\_\_\_\_ RESIDENCY  
\_\_\_\_\_ program from \_\_\_\_\_ to \_\_\_\_\_ to a total of \_\_\_\_\_ months.
5. During this period said applicant carried out performance:  
\_\_\_\_\_ Satisfactory and without filed complaints  
\_\_\_\_\_ Unsatisfactory — Explain on separate sheet

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

\_\_\_\_\_  
(Signature) (Date) (Print Name)

\_\_\_\_\_  
(Title)



# 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  
194 Hernan Cortez Ave., Suite 213  
Hagatna, Guam 96910

\_\_\_\_\_  
Signature

## 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

GBME-5.0



# GUAM BOARD OF MEDICAL EXAMINERS

*Applicant is requested to please complete this section of the form and mail to **each State Board** by which you are **now or have been** licensed to practice medicine/osteopathy. If needed, you may copy this form for additional copies.*

To Whom It May Concern:

In applying for a license to practice medicine/osteopathy in Guam, the Guam Board of Medical Examiners requires this form completed by each state wherein I hold or have ever held licensure. 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 Licensing Office  
194 Hernan Cortez Ave., Suite 213  
Hagatna, GU 96910

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
License No.: \_\_\_\_\_  
\_\_\_\_\_  
(Signature)

State of: \_\_\_\_\_

License No.: \_\_\_\_\_

Effective Date: \_\_\_\_\_

By Endorsement/Reciprocity with: \_\_\_\_\_

By Your State Board's Written Examination: \_\_\_\_\_

Is License Current? \_\_\_\_\_ If NO, Why Not? \_\_\_\_\_

Has the Physician ever been disciplined by your Board in any manner (revocation, probation, suspension, etc.)? \_\_\_\_\_

If YES, please explain and attach a copy of final order \_\_\_\_\_

Are there currently any formal charges pending against this physician's license? \_\_\_\_\_ If YES, please explain and attach a copy of complaint? \_\_\_\_\_

Is the Physician currently under investigation, or has he/she been investigated for any serious matter in the past five (5) years? \_\_\_\_\_ If YES, Please explain: \_\_\_\_\_

Has licensee ever been requested to appear before your Board? \_\_\_\_\_ If YES, please explain: \_\_\_\_\_

Additional comments, if any: \_\_\_\_\_

**(Board Seal)**

Name of Verifier: \_\_\_\_\_  
Title: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_



# GUAM BOARD OF MEDICAL EXAMINERS

## APPLICATION CHECKLIST FOR LIMITED LICENSE (Physicians in Graduate Training)

Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Medical School: \_\_\_\_\_ State: \_\_\_\_\_

- \_\_\_\_\_ Guam Board of Medical Examiners form 1 (**GBME-1**) application.
- \_\_\_\_\_ Photo – Signed and Dated, taken within the past six (6) months.
- \_\_\_\_\_ Guam Board of Medical Examiners Form (**GBME-7**) 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.
- \_\_\_\_\_ Sponsorship Letter from a currently licensed Physician/Clinic.
- \_\_\_\_\_ Verification from Institution
- \_\_\_\_\_ National Practitioner Data Bank self-query sent directly to GBME.
- \_\_\_\_\_ Detailed Practice Plan. (*Employer on Guam*)



# GUAM BOARD OF MEDICAL EXAMINERS

## APPLICATION FOR LIMITED MEDICAL LICENSURE

ATTACH  
2x2  
PHOTO  
HERE

### GENERAL INFORMATION AND INSTRUCTIONS

1. Please type or print.
2. Unsigned applications shall be considered incomplete and will be returned for signature.
3. Applications must include the following: **Completed checklist: GBME-1, GBME-7, GMBE-11, GBME-21 Form, and payment.**
4. Please make all check or money orders payable to *Treasurer of Guam*. *Online payments* can be made at [www.guamhplo.org/gbme](http://www.guamhplo.org/gbme) (additional 5% convenience fee).

#### A. IDENTIFICATION:

1. NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_
2. SOCIAL SECURITY NO.: \_\_\_\_\_ SEX: \_\_\_\_\_ M \_\_\_\_\_ F
3. PLACE OF BIRTH: \_\_\_\_\_ CONTACT NO.: \_\_\_\_\_
4. EMAIL ADDRESS: \_\_\_\_\_ NPI: \_\_\_\_\_
5. PRIMARY PRACTICE ADDRESS: \_\_\_\_\_  
\_\_\_\_\_
6. MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

#### B. EDUCATIONAL INFORMATION:

EDUCATIONAL BACKGROUND	NAME & ADDRESS	DATE GRADUATED	DEGREE
COLLEGE/UNIVERSITY			
MEDICAL SCHOOL			
POST GRADUATE TRAINING (Only list ACGME or AOA approved internship, residency, and fellowship)			

GBME-1





# GUAM BOARD OF MEDICAL EXAMINERS

## C. PROFESSIONAL INFORMATION:

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

\_\_\_\_\_  
\_\_\_\_\_

2. EXAMINATIONS TAKEN (List only if passed and list all parts and dates taken if applicable):

ECFMG: \_\_\_\_\_  
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NBME: Part 1: \_\_\_\_\_ Part 2: \_\_\_\_\_ Part 3: \_\_\_\_\_  
USMLE: Part 1: \_\_\_\_\_ Part 2: \_\_\_\_\_ Part 3: \_\_\_\_\_

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

FROM	TO	LOCATION	TYPE OF PRACTICE	REASON FOR DISCONTINUATION

4. ABMS (American Board of Medical Specialties) Specialty Certification:

a. I am ABMS BOARD CERTIFIED in the following:

<u>Specialty</u>	<u>Date Issued</u>	<u>Date Expired</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**(NOTE: ATTACHED COPY OF EACH ABMS BOARD CERTIFICATION)**

5. My area of practice is/are: \_\_\_\_\_

**I declare under penalty of perjury that the foregoing is true and correct.**

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# GUAM BOARD OF MEDICAL EXAMINERS

## RECORD OF PAYMENT

---

### 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: \_\_\_\_\_ SSN: \_\_\_\_\_

**Fee:** Please make all check or money orders payable to *Treasurer of Guam*. Online payments can be made at [www.guamhplo.org/gbme](http://www.guamhplo.org/gbme) (additional 5% convenience fee).

All fees are **NON-REFUNDABLE**.

Please check your request(s):

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2. ( )	License Fee	\$	250.00
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5. ( )	License Renewal	\$	250.00
6. ( )	Late Renewal Penalty Fee	\$	150.00
7. ( )	Inactive Status	\$	300.00
8. ( )	Reinstatement of License	\$	400.00
9. ( )	License Verification	\$	25.00
10. ( )	Re-Issuance (duplicate) License Certificate	\$	100.00
11. ( )	Re-Issuance (duplicate) License Card	\$	20.00
12. ( )	Physicians Practice Act	\$	10.00
13. ( )	Physicians Practice Act Admin. Rules & Regulations	\$	10.00
14. ( )	Photocopy (up to five (5) pages)	\$	4.00
15. ( )	Photocopy (each additional page)	\$	.50

### Interstate Medical Licensing Compact

1. ( )	Application Fee	\$	150.00
2. ( )	License Fee	\$	250.00
3. ( )	Letter of Qualification	\$	300.00

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

ACCOUNT #: 324156343

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

Field Receipt No.: \_\_\_\_\_ Date Paid: \_\_\_\_\_

GMBE-7



# GUAM BOARD OF MEDICAL EXAMINERS

## INITIAL APPLICATION INTERVIEW QUESTIONNAIRE

PAGE 1 OF 2

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE INDICATE YES or NO and INITIAL each entry.**

*(All "YES" answers to the following questions must be accompanied by a written statement with dates explaining the circumstances that must be acceptable to the GBME)*

	YES	NO	INITIAL
1 Has your license to practice medicine ever been revoked, suspended, or restricted Or has there been any disciplinary action taken against you in any state or territory?	___	___	_____
2 Have you ever been convicted of any felony or misdemeanor, except for minor traffic violations under the laws of any state or territory?	___	___	_____
3 Has any disciplinary action ever been taken against you by a government agency, Law enforcement agency, any peer review body, healthcare institution, or professional Medical society regarding your clinical or ethical performance as a physician?	___	___	_____
4 Have you voluntarily surrendered your medical license while under investigation in any state or territory?	___	___	_____
5 Have you ever been licensed or privileged to practice medicine by a government Jurisdiction including the military, public health or foreign government.	___	___	_____
6 Have you ever been denied a narcotic license, charged or convicted of a violation Of a Federal, State or Territorial Narcotic Laws, or asked to surrender your narcotic license?	___	___	_____
7 Has your staff privileges at any hospital/healthcare institution ever been denied, reduced or removed, or have you ever been subject to disciplinary action for reasons pertaining to your clinical or ethical performance as a physician?	___	___	_____
8 Have you ever voluntarily resigned or limited your staff privileges at any hospital/Health care institution while under formal or informal investigation by the institution or a committee thereof?	___	___	_____
9 Have you ever voluntarily resigned or withdrawn from a nation state or county medical society, association or organization while under a formal or informal investigation by the institution or a committee thereof?	___	___	_____



# GUAM BOARD OF MEDICAL EXAMINERS

## CONTINUATION OF INITIAL APPLICATION INTERVIEW QUESTIONNAIRE PAGE 2 OF 2

	YES	NO	INITIAL
10 Have you ever had a liability judgments(s) or/and legal settlement(s)?	___	___	_____
11 Have you ever changed your practice specialty?	___	___	_____
12 Have you ever been addicted to the use of narcotics, barbiturates, alcohol or other drugs	___	___	_____
13 Do you presently have a physical or mental health condition that can affect or is reasonably likely to affect your ability to perform your medical duties or affect your clinical judgment?	___	___	_____
14 Have you ever been licensed or applied for licensure on Guam? If "YES" Please indicate date: _____	___	___	_____

Under penalty of perjury, any misrepresentation to the Guam Board of Medical Examiners can constitute grounds for denial suspension or revocation of your medical license and prosecution to the full extent of the laws of Guam.

This form when completed must be submitted with your application for medical licensure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Signature of Reviewing Board Representative  
Guam Board of Medical Examiners

\_\_\_\_\_  
Date



# Guam Board of Medical Examiners

Applicant Full Legal Name: \_\_\_\_\_  
(First, Middle, Last, Suffix)

Date of Birth: \_\_\_\_\_  
(mm/dd/yyyy)

I, \_\_\_\_\_ being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete Guam Board of Medical Examiners' application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct, to include all previously submitted documents; and that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, licensing boards, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Guam Board of Medical Examiners or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Guam Board of Medical Examiners or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I understand that such collection of information may include physical documents, electronically transmitted documents and verbal discussion in person, via phone or electronic devices, e.g., via the internet.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)



# GUAM BOARD OF MEDICAL EXAMINERS

Applicant is requested to please complete this section of the form and mail to **each State Board** by which you are **now or have been** licensed to practice medicine/osteopathy. If needed, you may copy this form for additional copies.

To Whom It May Concern:

In applying for a license to practice medicine/osteopathy in Guam, the Guam Board of Medical Examiners requires this form completed by each state wherein I hold or have ever held licensure. 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 Licensing Office  
194 Hernan Cortez Ave. Suite 213  
Hagatna, GU 96910

Name: \_\_\_\_\_

Address: \_\_\_\_\_

License No.: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

State of: \_\_\_\_\_

License No.: \_\_\_\_\_

Effective Date: \_\_\_\_\_

By Endorsement/Reciprocity with: \_\_\_\_\_

By Your State Board's Written Examination: \_\_\_\_\_

Is License Current? \_\_\_\_\_ If NO, Why Not? \_\_\_\_\_

Has the Physician ever been disciplined by your Board in any manner (revocation, probation, suspension, etc.)? \_\_\_\_\_

If YES, please explain and attach a copy of final order \_\_\_\_\_

Are there currently any formal charges pending against this physician's license? \_\_\_\_\_ If YES, please explain and attach a copy of complaint? \_\_\_\_\_

Is the Physician currently under investigation, or has he/she been investigated for any serious matter in the past five (5) years? \_\_\_\_\_ If YES, Please explain: \_\_\_\_\_

Has licensee ever been requested to appear before your Board? \_\_\_\_\_ If YES, please explain: \_\_\_\_\_

Additional comments, if any: \_\_\_\_\_

**(Board Seal)**

Name of Verifier: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# GUAM BOARD OF MEDICAL EXAMINERS

## APPLICATION CHECKLIST FOR REINSTATEMENT OF LICENSE

Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Specialty: \_\_\_\_\_

\_\_\_\_\_ Guam Board of Medical Examiners form 1 (**GBME-8a**) application.

\_\_\_\_\_ Photo – Signed and Dated, taken within the past six (6) months.

\_\_\_\_\_ Guam Board of Medical Examiners Form (**GBME-7**) for record of payment.

\_\_\_\_\_ Guam Board of Medical Examiners Form (**GBME-9**) for CME Report. (2022, 2023, & Current)

\_\_\_\_\_ 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.

\_\_\_\_\_ Notarized copy of Medical License(s)

\_\_\_\_\_ Continental U.S.

\_\_\_\_\_ U.S. Territories

\_\_\_\_\_ National Practitioner Data Bank self-query sent directly to GBME.

\_\_\_\_\_ Detailed Practice Plan. (*Employer on Guam*)



# GUAM BOARD OF MEDICAL EXAMINERS

## APPLICATION FOR REINSTATEMENT OF LICENSURE

**ATTACH  
2x2  
PHOTO  
HERE**

### GENERAL INFORMATION AND INSTRUCTIONS

1. Please type or print.
2. Unsigned applications shall be considered incomplete and will be returned for signature.
3. Applications must include the following: **Completed checklist: GBME-7, GBME-8a, GMBE-9, GBME-11, GBME-21 Form, and payment.**
4. Please make all check or money orders payable to *Treasurer of Guam*. *Online payments* can be made at [www.guamhplo.org/gbme](http://www.guamhplo.org/gbme) (additional 5% convenience fee).

### A. IDENTIFICATION:

1. NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_
2. SOCIAL SECURITY NO.: \_\_\_\_\_ SEX: \_\_\_\_\_M \_\_\_\_\_F
3. PLACE OF BIRTH: \_\_\_\_\_ CONTACT NO.: \_\_\_\_\_
4. EMAIL ADDRESS: \_\_\_\_\_ NPI: \_\_\_\_\_
5. PRIMARY PRACTICE ADDRESS: \_\_\_\_\_  
\_\_\_\_\_
6. MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

### B. SPECIALTY & PROFESSIONAL EXPERIENCE:

My area of practice is/are: \_\_\_\_\_

1. I am American Board of Medical Specialties (ABMS) BOARD CERTIFIED in the following:

Area of Practice	Date
_____	_____
_____	_____
_____	_____





# GUAM BOARD OF MEDICAL EXAMINERS

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

**FROM      TO      LOCATION      TYPE OF PRACTICE      REASON FOR DISCONTINUATION**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(NOTE: ATTACH COPY OF EACH UPDATED CERTIFICATE OF BOARD CERTIFICATION)*

## C. CONTROLLED SUBSTANCE CERTIFICATION

1. Guam Registration No.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

2. DEA No.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

3. Schedule:

II	Controlled	YES	NO
	Non-Controlled	YES	NO
III	Controlled	YES	NO
	Non-Controlled	YES	NO
IV		YES	NO
V		YES	NO

## D. OTHER STATES OR U.S. TERRITORIES WHERE YOU ARE CURRENTLY LICENSED:

\_\_\_\_\_

## E. EMPLOYMENT HISTORY: LIST LAST THREE (3) EMPLOYERS

EMPLOYER NAME	ADDRESS	DATE
---------------	---------	------

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**I declare under penalty of perjury that the foregoing is true and correct.**

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# GUAM BOARD OF MEDICAL EXAMINERS

## RECORD OF PAYMENT

---

### 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: \_\_\_\_\_ SSN: \_\_\_\_\_

**Fee:** Please make all check or money orders payable to *Treasurer of Guam*. Online payments can be made at [www.guamhplo.org/gbme](http://www.guamhplo.org/gbme) (additional 5% convenience fee).

All fees are **NON-REFUNDABLE**.

Please check your request(s):

1. ( )	Application Fee	\$	150.00
2. ( )	License Fee	\$	250.00
3. ( )	USMLE Step 3 Examination	\$	530.00
4. ( )	Temporary License	\$	125.00
5. ( )	License Renewal	\$	250.00
6. ( )	Late Renewal Penalty Fee	\$	150.00
7. ( )	Inactive Status	\$	300.00
8. ( )	Reinstatement of License	\$	400.00
9. ( )	License Verification	\$	25.00
10. ( )	Re-Issuance (duplicate) License Certificate	\$	100.00
11. ( )	Re-Issuance (duplicate) License Card	\$	20.00
12. ( )	Physicians Practice Act	\$	10.00
13. ( )	Physicians Practice Act Admin. Rules & Regulations	\$	10.00
14. ( )	Photocopy (up to five (5) pages)	\$	4.00
15. ( )	Photocopy (each additional page)	\$	.50

### Interstate Medical Licensing Compact

1. ( )	Application Fee	\$	150.00
2. ( )	License Fee	\$	250.00
3. ( )	Letter of Qualification	\$	300.00

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

ACCOUNT #: 324156343

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

Field Receipt No.: \_\_\_\_\_ Date Paid: \_\_\_\_\_

GMBE-7



# GUAM BOARD OF MEDICAL EXAMINERS

## CME (CONTINUING MEDICAL EDUCATION) CATEGORIES

- Category I: Continuing Medical Education activities accredited by the American Medical Association and other activities approved in advance by the GBME. A minimum of 50% of the credit hours reported should be in this category.
- Category II: Continuing Medical Education Activities with non-accredited sponsorship.
- Category III: Medical teaching credit may be claimed for contact hours of teaching of medical students, interns, residents, and allied health professionals.
- Category IV: Papers, Publications, Books and Exhibits; ten (10) credit hours may be claimed for each paper published or given before a medical audience.
- Category V: Credit hours may be claimed for time spent with Self-Instruction activities (journal reading, studying medical audiovisual material), patient care review and Self-Assessment Examinations.
- Category VI: Other Meritorious Learning Experiences: These activities that do not fit into the other five (5) categories, but which the applicant feels represent valid continuing medical education. Submit a description of the activity for review by the Board.

## CME REQUIREMENTS

1. **Initial application for full licensure:**
  - a. A minimum of 100 credit hours of CME over the past two (2) years. Of this, at least 50%(50 credits) must be in Category I. (Attach copies.)
2. **Renewing a full medical license:**
  - a. A minimum of 50 credit hours (relevant in the field of your practice) of CME over the past two (2) years must be in category I. (Attach copies.)
  - b. At least two (2) credit hours of category I CME must be in Medical Ethics course(s). (Attach copies.)

**Note:** The Physician's Recognition Award obtained from the American Medical Association will be recognized as category I credits. Completion of an ACGME accredited residency or fellowship within the last year prior to application for licensure will meet the GBME CME requirements. Verification of such training must be provided to the GBME.





# GUAM BOARD OF MEDICAL EXAMINERS

## INITIAL APPLICATION INTERVIEW QUESTIONNAIRE

PAGE 1 OF 2

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE INDICATE YES or NO and INITIAL each entry.**

*(All "YES" answers to the following questions must be accompanied by a written statement with dates explaining the circumstances that must be acceptable to the GBME)*

		YES	NO	INITIAL
1	Has your license to practice medicine ever been revoked, suspended, or restricted Or has there been any disciplinary action taken against you in any state or territory?	___	___	_____
2	Have you ever been convicted of any felony or misdemeanor, except for minor traffic violations under the laws of any state or territory?	___	___	_____
3	Has any disciplinary action ever been taken against you by a government agency, Law enforcement agency, any peer review body, healthcare institution, or professional Medical society regarding your clinical or ethical performance as a physician?	___	___	_____
4	Have you voluntarily surrendered your medical license while under investigation in any state or territory?	___	___	_____
5	Have you ever been licensed or privileged to practice medicine by a government Jurisdiction including the military, public health or foreign government.	___	___	_____
6	Have you ever been denied a narcotic license, charged or convicted of a violation Of a Federal, State or Territorial Narcotic Laws, or asked to surrender your narcotic license?	___	___	_____
7	Has your staff privileges at any hospital/healthcare institution ever been denied, reduced or removed, or have you ever been subject to disciplinary action for reasons pertaining to your clinical or ethical performance as a physician?	___	___	_____
8	Have you ever voluntarily resigned or limited your staff privileges at any hospital/Health care institution while under formal or informal investigation by the institution or a committee thereof?	___	___	_____
9	Have you ever voluntarily resigned or withdrawn from a nation state or county medical society, association or organization while under a formal or informal investigation by the institution or a committee thereof?	___	___	_____



# GUAM BOARD OF MEDICAL EXAMINERS

## CONTINUATION OF INITIAL APPLICATION INTERVIEW QUESTIONNAIRE PAGE 2 OF 2

		YES	NO	INITIAL
10	Have you ever had a liability judgments(s) or/and legal settlement(s)?	___	___	_____
11	Have you ever changed your practice specialty?	___	___	_____
12	Have you ever been addicted to the use of narcotics, barbiturates, alcohol or other drugs	___	___	_____
13	Do you presently have a physical or mental health condition that can affect or is reasonably likely to affect your ability to perform your medical duties or affect your clinical judgment?	___	___	_____
14	Have you ever been licensed or applied for licensure on Guam? If "YES" Please indicate date: _____	___	___	_____

Under penalty of perjury, any misrepresentation to the Guam Board of Medical Examiners can constitute grounds for denial suspension or revocation of your medical license and prosecution to the full extent of the laws of Guam.

This form when completed must be submitted with your application for medical licensure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Signature of Reviewing Board Representative  
Guam Board of Medical Examiners

\_\_\_\_\_  
Date



# Guam Board of Medical Examiners

Applicant Full Legal Name: \_\_\_\_\_  
(First, Middle, Last, Suffix)

Date of Birth: \_\_\_\_\_  
(mm/dd/yyyy)

I, \_\_\_\_\_ being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete Guam Board of Medical Examiners' application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct, to include all previously submitted documents; and that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, licensing boards, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Guam Board of Medical Examiners or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Guam Board of Medical Examiners or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I understand that such collection of information may include physical documents, electronically transmitted documents and verbal discussion in person, via phone or electronic devices, e.g., via the internet.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)



# GUAM BOARD OF MEDICAL EXAMINERS

## APPLICATION CHECKLIST FOR TEMPORARY LICENSE

Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Specialty: \_\_\_\_\_

- \_\_\_\_\_ Guam Board of Medical Examiners form 1 (**GBME-1**) application.
- \_\_\_\_\_ Photo – Signed and Dated, taken within the past six (6) months.
- \_\_\_\_\_ Guam Board of Medical Examiners Form (**GBME-7**) 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.
- \_\_\_\_\_ Notarized copy of Medical License(s)
  - \_\_\_\_\_ Continental U.S.
  - \_\_\_\_\_ U.S. Territories
- \_\_\_\_\_ National Practitioner Data Bank self-query sent directly to GBME.
- \_\_\_\_\_ Detailed Practice Plan. (*Employer on Guam*)





# GUAM BOARD OF MEDICAL EXAMINERS

## APPLICATION FOR TEMPORARY MEDICAL LICENSURE

ATTACH  
2x2  
PHOTO  
HERE

### GENERAL INFORMATION AND INSTRUCTIONS

1. Please type or print.
2. Unsigned applications shall be considered incomplete and will be returned for signature.
3. Applications must include the following: **Completed checklist: GBME-1, GBME-7, GMBE-11, GBME-21 Form, and payment.**
4. Please make all check or money orders payable to *Treasurer of Guam*. *Online payments* can be made at [www.guamhplo.org/gbme](http://www.guamhplo.org/gbme) (additional 5% convenience fee).

#### A. IDENTIFICATION:

1. NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_
2. SOCIAL SECURITY NO.: \_\_\_\_\_ SEX: \_\_\_\_\_M \_\_\_\_\_F
3. PLACE OF BIRTH: \_\_\_\_\_ CONTACT NO.: \_\_\_\_\_
4. EMAIL ADDRESS: \_\_\_\_\_ NPI: \_\_\_\_\_
5. PRIMARY PRACTICE ADDRESS: \_\_\_\_\_  
\_\_\_\_\_
6. MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

#### B. EDUCATIONAL INFORMATION:

EDUCATIONAL BACKGROUND	NAME & ADDRESS	DATE GRADUATED	DEGREE
COLLEGE/UNIVERSITY			
MEDICAL SCHOOL			
POST GRADUATE TRAINING (Only list ACGME or AOA approved internship, residency, and fellowship)			

GBME-1



# GUAM BOARD OF MEDICAL EXAMINERS

## C. PROFESSIONAL INFORMATION:

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

\_\_\_\_\_  
\_\_\_\_\_

2. EXAMINATIONS TAKEN (List only if passed and list all parts and dates taken if applicable):

ECFMG: \_\_\_\_\_  
FLEX: Component 1: \_\_\_\_\_ Component 2: \_\_\_\_\_  
NBME: Part 1: \_\_\_\_\_ Part 2: \_\_\_\_\_ Part 3: \_\_\_\_\_  
USMLE: Part 1: \_\_\_\_\_ Part 2: \_\_\_\_\_ Part 3: \_\_\_\_\_

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

FROM	TO	LOCATION	TYPE OF PRACTICE	REASON FOR DISCONTINUATION

4. ABMS (American Board of Medical Specialties) Specialty Certification:

a. I am ABMS BOARD CERTIFIED in the following:

<u>Specialty</u>	<u>Date Issued</u>	<u>Date Expired</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

*(NOTE: ATTACHED COPY OF EACH ABMS BOARD CERTIFICATION)*

5. My area of practice is/are: \_\_\_\_\_

**I declare under penalty of perjury that the foregoing is true and correct.**

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# GUAM BOARD OF MEDICAL EXAMINERS

## RECORD OF PAYMENT

---

### 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: \_\_\_\_\_ SSN: \_\_\_\_\_

**Fee:** Please make all check or money orders payable to *Treasurer of Guam*. Online payments can be made at [www.guamhplo.org/gbme](http://www.guamhplo.org/gbme) (additional 5% convenience fee).

All fees are **NON-REFUNDABLE**.

Please check your request(s):

1. ( )	Application Fee	\$	150.00
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3. ( )	USMLE Step 3 Examination	\$	530.00
4. ( )	Temporary License	\$	125.00
5. ( )	License Renewal	\$	250.00
6. ( )	Late Renewal Penalty Fee	\$	150.00
7. ( )	Inactive Status	\$	300.00
8. ( )	Reinstatement of License	\$	400.00
9. ( )	License Verification	\$	25.00
10. ( )	Re-Issuance (duplicate) License Certificate	\$	100.00
11. ( )	Re-Issuance (duplicate) License Card	\$	20.00
12. ( )	Physicians Practice Act	\$	10.00
13. ( )	Physicians Practice Act Admin. Rules & Regulations	\$	10.00
14. ( )	Photocopy (up to five (5) pages)	\$	4.00
15. ( )	Photocopy (each additional page)	\$	.50

### Interstate Medical Licensing Compact

1. ( )	Application Fee	\$	150.00
2. ( )	License Fee	\$	250.00
3. ( )	Letter of Qualification	\$	300.00

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

ACCOUNT #: 324156343

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

Field Receipt No.: \_\_\_\_\_ Date Paid: \_\_\_\_\_

GMBE-7



# GUAM BOARD OF MEDICAL EXAMINERS

## INITIAL APPLICATION INTERVIEW QUESTIONNAIRE

PAGE 1 OF 2

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE INDICATE YES or NO and INITIAL each entry.**

*(All "YES" answers to the following questions must be accompanied by a written statement with dates explaining the circumstances that must be acceptable to the GBME)*

	YES	NO	INITIAL
1 Has your license to practice medicine ever been revoked, suspended, or restricted Or has there been any disciplinary action taken against you in any state or territory?	_____	_____	_____
2 Have you ever been convicted of any felony or misdemeanor, except for minor traffic violations under the laws of any state or territory?	_____	_____	_____
3 Has any disciplinary action ever been taken against you by a government agency, Law enforcement agency, any peer review body, healthcare institution, or professional Medical society regarding your clinical or ethical performance as a physician?	_____	_____	_____
4 Have you voluntarily surrendered your medical license while under investigation in any state or territory?	_____	_____	_____
5 Have you ever been licensed or privileged to practice medicine by a government Jurisdiction including the military, public health or foreign government.	_____	_____	_____
6 Have you ever been denied a narcotic license, charged or convicted of a violation Of a Federal, State or Territorial Narcotic Laws, or asked to surrender your narcotic license?	_____	_____	_____
7 Has your staff privileges at any hospital/healthcare institution ever been denied, reduced or removed, or have you ever been subject to disciplinary action for reasons pertaining to your clinical or ethical performance as a physician?	_____	_____	_____
8 Have you ever voluntarily resigned or limited your staff privileges at any hospital/Health care institution while under formal or informal investigation by the institution or a committee thereof?	_____	_____	_____
9 Have you ever voluntarily resigned or withdrawn from a nation state or county medical society, association or organization while under a formal or informal investigation by the institution or a committee thereof?	_____	_____	_____



# GUAM BOARD OF MEDICAL EXAMINERS

## CONTINUATION OF INITIAL APPLICATION INTERVIEW QUESTIONNAIRE PAGE 2 OF 2

	YES	NO	INITIAL
10 Have you ever had a liability judgments(s) or/and legal settlement(s)?	___	___	___
11 Have you ever changed your practice specialty?	___	___	___
12 Have you ever been addicted to the use of narcotics, barbiturates, alcohol or other drugs	___	___	___
13 Do you presently have a physical or mental health condition that can affect or is reasonably likely to affect your ability to perform your medical duties or affect your clinical judgment?	___	___	___
14 Have you ever been licensed or applied for licensure on Guam? If "YES" Please indicate date: _____	___	___	___

Under penalty of perjury, any misrepresentation to the Guam Board of Medical Examiners can constitute grounds for denial suspension or revocation of your medical license and prosecution to the full extent of the laws of Guam.

This form when completed must be submitted with your application for medical licensure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Signature of Reviewing Board Representative  
Guam Board of Medical Examiners

\_\_\_\_\_  
Date



# Guam Board of Medical Examiners

Applicant Full Legal Name: \_\_\_\_\_  
(First, Middle, Last, Suffix)

Date of Birth: \_\_\_\_\_  
(mm/dd/yyyy)

I, \_\_\_\_\_ being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete Guam Board of Medical Examiners' application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct, to include all previously submitted documents; and that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, licensing boards, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Guam Board of Medical Examiners or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Guam Board of Medical Examiners or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I understand that such collection of information may include physical documents, electronically transmitted documents and verbal discussion in person, via phone or electronic devices, e.g., via the internet.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)