GUAM BOARD OF MEDICAL EXAMINERS

Dear Applicant:

Thank you for your interest in applying for a license to practice medicine in Guam.

Enclosed are the instructions and forms for your full licensure application. If necessary the Guam Board of Medical Examiners (GBME) may require additional information if it's not available through the Federation Credential Verification Service (FCVS) of the Federation of State Medical Boards (FSMB), National Practitioner's Data Bank (NPDB) and the American Medical Association (AMA) primary verification services. The GBME meets on the third (3rd) Wednesday of each month. Completed applications with all required documents received on or before the fifth (5th) work day prior to the scheduled meeting will be placed on the agenda.

Please be informed that prior to any Board action on your licensure application you must request for your "National Practitioner Data Bank" report and to be sent directly to the Board office.

Should you need further assistance, please do not hesitate to contact the Health Professional Licensing Office at (671) 735-7406-11, Facsimile (671) 735-7413, or write to our street address at 651 Legacy Square Commercial Complex, South Route 10, Suite 9, Mangilao, GU 96913.

Enclosures:
Application Checklist for Full Medical Licensure
(GBME-1 Application for Initial Full Medical Licensure)
(GBME-7 Record of Payment)
(GBME-9 Continuing Medical Education Report)
(GBME-11 Initial Application/Interview Questionnaire)
(GBME-21 Release of Information)
(AMA & FSMB (FCVS) Physician Profile Request)
(NPDB Request Form)

GUAM BOARD OF MEDICAL EXAMINERS

APPLICATION CHECKLIST

FOR

FULL MEDICAL LICENSURE

Name:_____ Date of Application: _____

_____ Guam Board of Medical Examiners form 1 (GBME-1) for initial 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.

_____ 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.

_____ Original medical licenses from other jurisdiction(s) or notarized copy(s) of the original(s) U.S. or Canadian if requested by the GBME.

_____ Certificate of Medical Education form (GBME-3) if requested by the GBME.

_____ Certification of Internship/Residency Program form (GBME-4) if requested by the GBME.

_____ Hospital/Practice Verification (GBME-5.0) form if requested by the GBME.

_____ State Board Verification (GBME-5.2) form if requested by the GBME.

_____ Qualifying Examination Certificates that you have completed in accordance to GBME requirements for each new applicant: FLEX; NBME; USMLE; OTHER.

_____ ECFMG certificate for foreign medical graduates or notarized copy.

_____ National Practitioner's Data Bank self-inquiry sent to the GBME directly.

_____ AMA profile submitted to be sent to GBME directly.

_____ FCVS (Federation Credential Verification Service) submitted to be sent to the GBME directly.

Note: If required items are not submitted with application, then the application will be considered incomplete and will not be processed until all items requested are included.

651 Legacy Square Commercial Center • S. Rt. 10, Suite 9 • Mangilao, GU 96913

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: _____

III. Fee: Please make all check or money orders payable to ***TREASURER OF GUAM***. 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

NOTE: *Mail this form to the Guam Board of Medical Examiners, 651 Legacy Square Commercial Complex S. Rt. 10, Suite 9, Mangilao, GU 96913*

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

Field Receipt No. _____ Date Paid: _____

GBME-7 (Rev. Jan. 2002)

ATTACH
2 X 2
PHOTO
HERE

GUAM BOARD OF MEDICAL EXAMINERS

APPLICATION FOR INITIAL FULL MEDICAL LICENSURE

GENERAL INFORMATION AND INSTRUCTIONS

1. Please type or print.
2. Unsigned application shall be considered incomplete and will be returned for signature.
3. Application must include the following: **Completed check list; GBME-1, GBME-7, GBME-9, GBME-11, GBME-21** Forms, and **payment.**
4. Make Check or Money Order payable to: ***"Treasurer of Guam" and mail to P. O. Box 2816, Hagatna, GU 96932."***

A. IDENTIFICATION:

1. NAME: _____
   (LAST) (FIRST) (MIDDLE) (MAIDEN)
2. SOCIAL SECURITY NO.: _____ SEX: _____ M _____ F
3. DATE OF BIRTH: _____ PLACE OF BIRTH: _____
4. PERMANENT ADDRESS: _____
   _____
5. MAILING ADDRESS: _____
   (STREET OR P. O. BOX)
   _____
   (CITY) (STATE) (ZIP)
   _____
   (EMAIL ADDRESS) (CONTACT #)

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(s))			

C. PROFESSIONAL INFORMATION:

1. List ***past and current*** medical licenses 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 last 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** (American Board of Medical Specialties) BOARD CERTIFIED in the following:

Specialty	Date Issued	Date Expired
_____	_____	_____
_____	_____	_____
_____	_____	_____

(NOTE: ATTACH COPY OF EACH ABMS BOARD CERTIFICATION)

5. My area of practice is/are: _____

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'S SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS
_____ DATE OF _____, _____
NOTARY PUBLIC: _____
COMMISSION EXPIRES: _____
(DATE)

(NOTARY SEAL)

GUAM BOARD OF MEDICAL EXAMINERS

INITIAL APPLICATION INTERVIEW QUESTIONNAIRE

Name of Applicant: _____

Date: _____

LEASE 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
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?	____	____	_____
Have you ever been convicted of any felony or misdemeanor, except for minor traffic violations under the laws of any state or territory?	____	____	_____
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?	____	____	_____
Have you voluntarily surrendered your medical license while under investigation in any state or territory?	____	____	_____
Have you ever been licensed or privileged to practice medicine by a government jurisdiction including the military, public health or foreign government.	____	____	_____
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?	____	____	_____
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?	____	____	_____
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?	____	____	_____
Have you ever voluntarily resigned or withdrawn from a national state or county medical society, association or organization while under a formal or informal investigation by the institution or a committee thereof?	____	____	_____

CONTINUATION OF INITIAL APPLICATION INTERVIEW QUESTIONNAIRE
PAGE 2 OF 2

10. Have you ever had a liability judgment(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 Date
Guam Board of Medical Examiners

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:

Guam Board of Medical Examiners
Legacy Square Commercial Complex
South Route 10, Suite 9
Mangilao, GU 96913

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: _____

Name of Verifier: _____

Title: _____

Signature: _____

(Board Seal)

Date: _____

651 Legacy Square Commercial Complex • S. Route 10, Suite 9 • Mangilao, GU 96913

GUAM BOARD OF MEDICAL EXAMINERS

Applicant to sent 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 riles favorable or otherwise regarding myself, directly to:

Guam Board of Medical Examiners
Legacy Square Commercial Complex
South Route 10, Suite 9
Mangilao, GU 96913

_____
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: _____

SEAL

Date: _____

GUAM BOARD OF MEDICAL EXAMINERS

CERTIFICATE OF MEDICAL EDUCATION

THE APPLICANT BELOW IS APPLYING FOR LICENSURE TO PRACTICE MEDICINE IN GUAM. PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN ***DIRECTLY*** TO THE BOARD AT **651 LEGACY SQUARE COMMERCIAL CENTER S. ROUTE 10, STE. 9, MANGILAO, GU 96913.**

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 AUTHORIZE 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'S TRANSCRIPT.**

S E A L

O F

S C H O O L

SIGNATURE: _____

NAME: _____

TITLE: _____

GUAM BOARD OF MEDICAL EXAMINERS

CERTFICATION 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.

PART A – TO BE COMPLETED BY APPLICANT

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

I HEREBY AUTHORIZE RELEASE OF INFORMATION TO THE GUAM Board OF MEDICAL EXAMINERS RELATIVE TO MY COMPLIANCE OF THE INTERNSHIP/RESIDENCY PROGRAM.

_____ _____
(Signature) (Date)

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

1. Name of Applicant: _____
   (Last) (First) (Middle)
2. Name of Institution: _____
3. Address of Institution: _____
   (Address)

   _____
   (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 PROVIED 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)

651 Legacy Square Commercial Complex • S. Route 10, Ste. 9 • Mangilao, GU 96913

GUAM BOARD OF MEDICAL EXAMINERS

I, _____, do hereby authorize the Guam Board of Medical Examiners to request information from appropriate individual/agency/organization to verify my qualifications and/or current licensure standing with other Medical Boards.

I understand that request for verifications will be forwarded in accordance to the established administrative rules and regulations.

_____ _____

(Signature) *(Date)*

651 Legacy Square Commercial Complex • S. Route 10, Suite 9 • Mangilao, GU 96913

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: 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

651 Legacy Square Commercial Complex • South Rt. 10, Suite 9 • Mangilao, GU 96913

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 accredidated 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.*

American Medical Association

Physicians dedicated to the health of America

Telephone: 800-621-8335
Fax: 312 464-5900

AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA). Profiles also can be ordered online through ***AMA Physician Profiles*** located at http://www.ama-assn.org/go/AMAProfiles. AMA Customer Service is available for ordering assistance at 800-621-8335, 24 hours a day, seven days a week.

******Join or renew your AMA membership today---call 800-AMA-3211******

Standard Mail Service (within 10 business days)

Indicate AMA Membership Status:

_____Member Physician	No charge
_____Nonmember Physician	$33 per profile

****Prices are subject to change without advance notice.***

Credit card payment is accepted. Checks should be made payable to the American Medical Association, 75 Remittance Drive Suite #6397, Chicago IL 60675-6397. Orders faxed to the AMA must include credit card information for billing purposes.

___ VISA ___ American Express ___ MasterCard Charge Amount: **$**_____

Credit Card Number _____ Expiration Date: ____/____/____

Name on Credit Card: _____

Billing Address: _____

Approval Signature_____ Daytime Telephone: _____

Part 1: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing board:

Board Name: _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

_____

Physician Name (first, middle, last, suffix)

_____ ____/____/____ _____

Place of Birth Date of Birth Social Security Number

_____ _____

E-mail Address Medical Education Number (optional)

_____

Preferred Mailing Address

_____ (_____)_____-_____

City, State, Zip Code Telephone Number

The above address is my OFFICE ___ HOME ____ OTHER ___

If address is home or other, please complete this section.

_____

Primary Office Address

_____ (_____)_____-_____

City State Zip Code Office Telephone Number

Part 3: Medical Education and Other Information

Medical School of Graduation _____ Year of Graduation _____

DEA Number _____ ECFMG Number _____

Residency Training

Residency Training (institution/hospital name, location, and years) _____

_____

_____

Hospital Admitting Privileges

Hospital Name _____ City/State _____

_____ _____

_____ _____

_____ _____

Group Practice Affiliation(s)

Group Practice Name _____ City/State _____

_____ _____

_____ _____

_____ _____

Physician Agreement

Agreement must be signed in order to process your request.
AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X_____ _____/_____/_____
Signature Date