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 CHECK LIST
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.

GBME-Checklist for full licensure (Rev. 10/2006)

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

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

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<tr>
<th>EDUCATIONAL BACKGROUND</th>
<th>NAME &amp; ADDRESS</th>
<th>DATE GRADUATED</th>
<th>DEGREE</th>
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<td>COLLEGE/UNIVERSITY</td>
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<td>MEDICAL SCHOOL</td>
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<tr>
<td>POST GRADUATE TRAINING</td>
<td>(Only list ACGME or AOA approved internship, residency and fellowship(s))</td>
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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: __________________
   
   

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

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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: ____________________________ (NOTARY SEAL)

COMMISSION EXPIRES: ____________________________ (DATE)
GUAM BOARD OF MEDICAL EXAMINERS

INITIAL APPLICATION INTERVIEW QUESTIONNAIRE

PAGE 1 OF 2

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.

<table>
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<th>YES</th>
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651 Legacy Square Commercial Complex • S. Rt. 10, Ste. 9 • Mangilao, GU 96913
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
Guam Board of Medical Examiners

______________________________  ______________________________
Date

GBME-11 (Revised 10/2006)
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.: _______________________

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: ___________________________
Date: ___________________________

Board Seal

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

GMBE-5.2 (Rev. 2/2003)
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 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

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

651 Legacy Square Commercial Complex • S. Route 10, Ste. 9 • Mangilao, GU 96913
GBME-5.0 (Rev. 2/2003)
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.

   SEAL
   ____________________________________________________________
   SIGNATURE: ____________________________
   OF
   NAME: ____________________________________________________________
   SCHOOL
   TITLE: ____________________________________________________________

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

GBME-3 (Rev. 2/2003)
GUAM BOARD OF MEDICAL EXAMINERS

CERTIFICATION 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 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) __________

   651 Legacy Square Commercial Complex • S. Route 10, Ste. 9 • Mangilao, GU 96913
   GBME-4 (Rev. 2/2003)
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)
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]

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Sponsored By:</th>
<th>Dates Attended</th>
<th>Accredited/Approved by: (AMA, AAFP, ACOG, etc.)</th>
<th>Category</th>
<th>Credit Hours</th>
</tr>
</thead>
</table>

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

GBME-9 (Rev. 10/2006)
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.
American Medical Association
Physicians dedicated to the health of America

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

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/AMAPhysicianProfiles. 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 ____________________________