GUAM BOARD OF MEDICAL EXAMINERS

Instructions for Application for Medical Licensure

Thank you for your interest in applying for a license to practice medicine in Guam. Following are the instructions for your full licensure application.

The online Uniform Application for Physician State Licensure (UA) was developed to simplify the licensure application process by eliminating redundancy. Once the core UA is completed, it can be sent when applying to another participating board without the need to reenter information. Updates can be made as needed.

Credentials verification is part of the overall licensure process. The Federation Credentials Verification Service (FCVS) can be used for credentials verification but it is not required. If necessary, the Guam Board of Medical Examiners (GBME) may require additional information if not available through FCVS, the National Practitioner Data Bank (NPDB), and the American Medical Association (AMA) primary verification services.

The GBME meets on the second Wednesday of each month. Completed applications with all required documents received on or before the fifth work day prior to the scheduled meeting will be placed on the agenda.

Use the checklist in this packet to ensure you complete all requirements. For further assistance, please do not hesitate to contact the Health Professional Licensing Office by calling (671) 735-7406-7411, faxing to (671) 735-7410, or writing to our mailing address at 123 Chalan Kareta, South Route 10 Mangilao, Guam 96913.

Credentials Verification and the UA

Verification of documents related to a physician's identity, education, training, and more is an important part of the overall licensure process. You can provide your credentials to the Board directly, or you can use the Federation Credentials Verification Service (FCVS) instead. After FCVS staff verifies credentials from primary sources, a permanent profile of the verified credentials is created. This profile can be updated as needed and sent to boards and other entities without having each item verified again.

If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education Verification, Postgraduate Training Verification, or Fifth Pathway Verification forms included in this packet. Do not send any identity documents, transcripts, certificates, or examination scores to the Board. FCVS handles all of this for you.

- To use FCVS, visit https://portal.fsmb.org/MyFsmb/ and click on the FCVS graphic, then sign in. If the link doesn't work, visit http://www fsmb.org/ and click on FCVS in the Licensure menu. Complete an Initial Application if you are using FCVS for the first time. Complete a Subsequent Application if you need to update your FCVS profile. Designate your profile to be received by the Guam Board of Medical Examiners.

- For assistance, contact FCVS by using the messaging tool within FCVS or by calling 888-275-3287 with your five or six digit FCVS ID number.

If you are **not** using FCVS for credentials verification,

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if your name is not the same on all of your submitted documents.

- Contact each appropriate examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at http://www fsmb.org/uniform-application/ua-faq/.

- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form. The UA Medical School Verification form should be accompanied by a copy of your diploma if you graduated from that school. A certified transcript must be sent to the Board from the

appropriate educational institution. If your transcript or any other document submitted is in a language other than English, also provide a certified translation.

- All international medical graduates must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and provide evidence of completion of three (3) years of postgraduate training with at least two (2) of those years completed in the USA. Postgraduate training must occur after graduation. If you are an international medical graduate, request from ECFMG that a notarized copy of your ECFMG certificate, a copy of your Status Report of ECFMG Certification, and your Fifth Pathway Program Certificate (if applicable) be sent to the Board. See the UA FAQ at the link above for contact information.

Applying for Licensure

As part of the online UA, you will be asked to complete a chronology of activities of all working and non-working time since medical school graduation and provide details of any malpractice liability claims. Having this information on hand before you begin will help you to complete the UA more efficiently.

To use the UA, visit https://portal fsmb.org/MyFsmb/ and click on the UA graphic, then sign in. If the link doesn't work, visit http://www.fsmb.org/ and click on Uniform Application in the Licensure menu.

Please note:

- Information on USMLE, FLEX, and SPEX exams and medical licenses issued in the U.S. and Canada will be pre-filled in your UA. All other examination information (NBME, NBOME, COMLEX, LMCC, state board exams, etc.) must be entered. If you see incorrect license information, send an email to ua@fsmb.org with the correct information.

- Each license must be verified by the board that issued the license. See the resource provided at http://www.fsmb.org/uniform-application/ for information on fees and the preferred verification method for each medical board. Use the UA Licensure Verification Form in this packet for boards that need a written request. If the verifying board uses VeriDoc or another method, use VeriDoc or the preferred method instead of using the UA form.

For questions or assistance, see the UA FAQ at http://www fsmb.org/uniform-application/ua-faq/. If your question is not listed, contact UA customer service at 800-793-7939 or ua@fsmb.org.

Additional Requirements and Information

- All applicants must request the American Medical Association's Physician Profile to be sent to the Board. Request the AMA Physician Profile Data Report online at https://profiles.ama-assn.org/amaprofiles/. There is a fee for non-members. Call customer service at 800-665-2882 for assistance.

- The National Practitioner Data Bank Self-Query must also be received by the Board before any action is taken on your licensure application. Visit https://www.npdb hrsa.gov/ext/selfquery/SQHome.jsp to begin the process for a self-query. Follow all instructions given. A pdf of the Self-Query report may be sent to the GBME, or you may request a mailed copy so that the Self-Query report is mailed directly to you. You must then mail (do not fax) all of the original report (not photocopies) directly to the GBME. For assistance, email help@npdb hrsa.gov or call 800-767-6732.

Continuing Medical Education (CME) 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 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.

Requirements and Qualifications for Temporary License

A. The Board may issue a Temporary License to practice medicine in Guam to an applicant who:

a) has passed a medical licensing examination as required for full license;

b) has a current, unrestricted medical license in another state, the District of Columbia, a territory or possession of the United States or Canada, and;

c) the following documents pending arrival of other documents required for licensure:

1. Online Uniform Application
2. Uniform Application addendum and applicable UA forms, including notarized UA Affidavit/ Authorization form with 2" x 2" signed and dated photograph taken within the past three (3) months;
3. Notarized copy of a current U.S., U.S. Territory license;
4. Payment of appropriate fee;
5. A letter of endorsement to practice in Guam from a currently licensed physician practicing in Guam;
6. National Practitioner Data Bank and FSMB reports; and
7. Detailed Practice Plan.

B. The temporary license if ***valid only*** for a period of three (3) months.

C. The temporary license becomes null and void upon issuance of a regular medical license, upon expiration, or upon withdrawal by Board.

D. It is the responsibility of the applicant to ensure that the Board receives all required documents prior to the expiration date of the temporary license.

E. An applicant with current or previous disciplinary or Board action(s) or reports shall be requested to make a personal appearance for interview to explain his/her standing.

Uniform Application Checklist for Full Licensure

Send this checklist with all other materials being sent to the Board.

Applicant Name _____ Date of Application _____

Name of Medical School Attended _____ State _____

NOTE: If required items are not submitted, then the application will be considered incomplete and will not be processed until all items requested are received.	**NOT using FCVS to verify credentials**	**Using FCVS to verify credentials**
Completed and submitted online Uniform Application to the Board.	☐	☐
Notarized UA Affidavit and Authorization for Release of Information form with 2x2 photo taken within the past 3 months sent to the Board.	☐	☐
Verification of licenses sent to the Board from all boards with which you have ever held any healthcare license. You may use VeriDoc or a board's preferred electronic verification instead of Form #1.	☐	☐
Current notarized copy/copies of U.S. (state/territories) or Canadian medical license(s) and certificate(s) with expiration date(s) sent to the Board	☐	☐
Completed addendum with pages 1-3 and any other documentation (ABMS certificates, details from questions) plus application fee sent to the Board.	☐	☐
Sent Hospital/Practice Verification form (Addendum page 4) and any applicable fee to verifying organizations.	☐	☐
American Medical Association Physician's Profile sent to the Board.	☐	☐
National Practitioner Data Bank Self-Query sent to the Board.	☐	☐
Detailed practice plan sent to the Board.	☐	☐
Supporting documentation of any legal name change sent to the Board.	☐	FCVS handles
Medical Education Verification form (Form #2) sent to the Board by all medical schools attended	☐	FCVS handles
Medical School Transcripts sent to the Board by your medical school.	☐	FCVS handles
A copy of your postgraduate training certificate(s) submitted to the Board.	☐	FCVS handles
Postgraduate Training Verification form (Form #3) sent to the Board from all programs you attended.	☐	FCVS handles
Fifth Pathway form, if applicable (Form #4), sent to the Board from your medical school and institution	☐	FCVS handles
Examination Transcripts sent to the Board.	☐	FCVS handles
Foreign Medical Graduates: Notarized copy of ECFMG Certificate or original certificate sent to the Board.	☐	FCVS handles

FOR BOARD USE ONLY

Board Review/Action _____ Date _____ Comment _____

Uniform Application Checklist for
Limited (Physicians in Graduate Training) License

Send this checklist with all other materials being sent to the Board.

Applicant Name _____ Date of Application _____

Name of Medical School Attended _____ State _____

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

Completed and submitted online Uniform Application to the Board	☐
Sent each of the following to the Board:	
- Notarized UA Affidavit and Authorization for Release of Information form with 2x2 photo taken within the past 3 months	☐
- National Practitioner Data Bank Self-Query	☐
- Sponsorship Letter from a currently licensed physician/clinic	☐
- Detailed practice plan	☐
- Completed pages 1 and 2 of the UA Addendum	☐
- Copy of each ABMS Certification	☐
- Written statement(s) with dates explaining circumstances for questions answered "Yes"	☐
- $150 application fee and $125 limited license fee	☐
Postgraduate Training Verification form (Form #3) sent to the Board from your training institution	☐

FOR BOARD USE ONLY

Board Review/Action _____ Date _____ Comment _____

Uniform Application Checklist for Reinstatement License

Send this checklist with all other materials being sent to the Board.

Applicant Name _____ Date of Application _____

Name of Medical School Attended _____ State _____

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

Completed and submitted online Uniform Application to the Board	☐
Sent each of the following to the Board:	
- Notarized UA Affidavit and Authorization for Release of Information form with 2x2 photo taken within the past 3 months	☐
- Current notarized copy/copies of U.S. (state/territories) or Canadian medical license(s) and certificate(s) with expiration date(s)	☐
- National Practitioner Data Bank Self-Query	☐
- Completed pages 1 and 2 of the UA Addendum	☐
- Copy of each ABMS Certification	☐
- Written statement(s) with dates explaining circumstances for questions answered "Yes"	☐
- $400 reinstatement of license fee	☐

FOR BOARD USE ONLY

Board Review/Action _____ Date _____ Comment _____

Uniform Application Checklist for Temporary License

Send this checklist with all other materials being sent to the Board.

Applicant Name _____ Date of Application _____

Name of Medical School Attended _____ State _____

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

Completed and submitted online Uniform Application to the Board	☐
Sent each of the following to the Board:	
- Notarized UA Affidavit and Authorization for Release of Information form with 2x2 photo taken within the past 3 months	☐
- Current notarized copy/copies of U.S. (state/territories) or Canadian medical license(s) and certificate(s) with expiration date(s)	☐
- National Practitioner Data Bank Self-Query	☐
- Letter of Endorsement	☐
- Detailed practice plan	☐
- Completed pages 1 and 2 of the UA Addendum	☐
- Copy of each ABMS Certification	☐
- Written statement(s) with dates explaining circumstances for questions answered "Yes"	☐
- $150 application fee and $125 temporary license fee	☐

FOR BOARD USE ONLY

Board Review/Action _____ Date _____ Comment _____

FOR OFFICE USE ONLY: **Payment** ☐ **Check** _____ ☐ **Cash** ☐ **Money Order**

Field Receipt No.: _____ Date Paid: _____ Applicant: _____

GUAM BOARD OF MEDICAL EXAMINERS ADDENDUM

Complete this addendum as instructed. Mail pages 1-3 with fees and any additional documentation needed by the Board to *Guam Board of Medical Examiners, 123 Chalan Kareta,South Route 10. Mangilao, GU 96913.* Mail page 4 and any verification fee needed to each hospital/organization in which you have practiced.

Record of Payment

Make all check/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.	☐	Limited/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) _____	$ 0.50

American Board of Medical Specialties - Specialty Certification

☐ I am not ABMS Board Certified.

☐ I am ABMS Board Certified in the following:

Specialty	Date Issued	Date Expired
_____	_____	_____
_____	_____	_____

Note: Attach a copy of each ABMS Certification to this addendum.

Area(s) of Practice

My area(s) of practice is/are:_____

Educational Information

Pre-Medical College/University Name and Address	Date Graduated	Degree
_____	_____	_____
_____	_____	_____

Initial Application Interview Questionnaire

Please indicate "Yes" or "No" to each question and initial each entry. All "YES" answers 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 U.S. territory?	☐	☐	____
2.	Have you ever been convicted of any felony or misdemeanor, except for minor traffic violations under the laws of any state or U.S. 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 U.S. 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.	Have 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/ healthcare institution while under formal or informal investigation by the institution or a committee thereof?	☐	☐	____
9.	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?	☐	☐	____
10.	Have you ever had a liability judgment(s) and/or 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 misinterpretation 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.

_____ _____

Applicant Signature *Date*

_____ _____

Printed Name and Signature of Reviewing GBME Representative *Date*

Continuing Medical Education Report

See page 3 of the Instructions for definitions of each Continuing Medical Education category. 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 GMBE CME requirements. Verification of such training must be provided to the GBME.

CME requirements for 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.)

CME requirements for 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.)

List all Continuing Education Participation below. Please print or type. Attach copies of all Category 1 Certificates. You may copy this page for listing additional continuing education courses if needed.

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*

Hospital Verification / Practice Verification

To be completed by applicant:

My signature below authorizes the below listed hospital/organization to release any and all information in your files, favorable or otherwise, regarding myself, directly to:

Guam Board of Medical Examiners
123 Chalan Kareta South Route 10
Mangilao, Guam 96913

Applicant Signature _____ Date _____

Applicant Printed Name _____ Date of Birth _____

Hospital/Practice Name _____

Hospital/Practice Street Address _____

City/State/Zip/Country _____

To be completed by Hospital/Practice Staff only:

Position(s) Held: _____

Committees, Department: _____

Applicable Dates: _____

Was there any adverse information occurrence during hospital affiliation? ☐ Yes ☐ No

If yes, please describe in the space below.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____
Print name: _____
Title: _____
Date: _____
Phone number: _____ Fax number: _____
Email: _____

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

When completed, please send this form to the Guam Board of Medical Examiners at the address above. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at http://www.fsmb.org/policy/contacts.

Please send this form to: Guam Board of Medical Examiners
123 Chalan Kareta South Route 10
Mangilao, GU 96913-6304

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

_____
Applicant's signature (must be signed in the presence of a notary)

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at http://www.fsmb.org/licensure/uniform-application/ to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at http://www.fsmb.org/policy/contacts to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to my license number _____ to the board at the address listed below.

Board name	Guam Board of Medical Examiners
Mailing address	123 Chalan Kareta South Route 10
City/State/Zip	Mangilao, GU 96913-6304

Applicant signature _____ Date_____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____

Name of licensee (last, first, middle, suffix) _____

License type _____ License number _____ Issue date _____ Expiration date _____

1. Is this license current? If not current, please explain: ☐ Yes ☐ No

2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

Title _____ Date _____

(If no seal is available, this form must be notarized.)

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma awarded: _____

Name of school _____

**The social security number is to be used for purposes of identification only and may not be used or any other reason.*

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name	Guam Board of Medical Examiners
Mailing address	123 CHalan Kareta South Route 10
City/State/Zip	Mangilao, GU 96913-6304

Applicant signature _____ Date _____

Section 2: Medical or Osteopathic School Verification

School name _____

Complete address w/country _____

School name if different when applicant attended _____

Hours of undergraduate education required for admission _____ Total weeks of education applicant attended _____

Attendance (mm/yyyy) from _____ to _____ Graduation date _____ Degree awarded _____

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? **If yes,** indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes ☐ No ☐

☐ Personal or family	From _____ to	☐ Approved	☐ Unapproved
☐ Academic remediation	From _____ to	☐ Approved	☐ Unapproved
☐ Health	From _____ to	☐ Approved	☐ Unapproved
☐ Financial	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a joint degree program	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a non-research special study (e.g., fellowship, intl. experience)	From _____ to _____	☐ Approved	☐ Unapproved
☐ Other _____	From _____ to _____	☐ Approved	☐ Unapproved

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? **If yes,** indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

☐ Academic	From _____ to	☐ Documentation attached
☐ Unprofessional conduct	From _____ to	☐ Documentation attached
☐ Behavioral reasons	From _____ to	☐ Documentation attached
☐ Other _____	From _____ to _____	☐ Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title _____ Date _____

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

Postgraduate Training Verification Form (Form #3)

Institution Name: ____

Institution Address: ____

____

Affiliated School: ____

Applicant: Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

Program Director or designated Official: Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

Section 1: To be completed by the Applicant.

Name: ________________________________ **Suffix** _____ **Practitioner type: M.D.** ☐ **D.O.** ☐

Date of birth: ____________ **(mm/dd/yyyy)** **SSN*** ________________________________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Name if different when diploma awarded: ________________________________

Board Information: To be completed by the applicant.

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below: Mail the completed form to:

Board Name: Guam Board of Medical Examiners

Mailing address: 123 Chalan Kareta South Route 10. Mangilao, GU 96913-6304

Applicant Please Sign Here →

Applicant Signature ________________________________ **Date** ____________

Section 2 : Program Participation :

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected comple ion date in the "To" field.

Use one section per Department/Specialty. If he Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Report Internships, Residencies and Fellowships separately.

Training Level: _____ (e.g., 1, 2, 3, etc.)

☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ________________________________

From: __/__/______ **To:** __/__/______

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)

☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ________________________________

From: __/__/______ **To:** __/__/______

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)

☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ________________________________

From: __/__/______ **To:** __/__/______

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the appropriate responses and explain any “Yes” or omitted response(s) on a separate sheet of paper. Attach pages as needed.

1. Did this individual ever take a leave of absence or break from his/her training? ---------------- ☐ Yes ☐ No

2. Was this individual ever placed on probation? -- ☐ Yes ☐ No

3. Was this individual ever disciplined or placed under investigation? -------------------------------- ☐ Yes ☐ No

4. Were any negative reports for behavioral reasons ever filed by instructors? -------------------- ☐ Yes ☐ No

5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ---------------- ☐ Yes ☐ No

Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form. This section MUST be signed by the program director (M.D. or D.O. only). **(Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)**

Signature: ________________________________

Print name: ________________________________

Title: ________________________________

Email address: ________________________________

Phone Number: ____________________ **Date:** ____________

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Fifth Pathway Verification Form (Form #4)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

Program Director or Designated Official: Complete Section 2 of this form. Mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma was awarded: _____

Name of medical school _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

Board name	Guam Board of Medical Examiners
Mailing address	123 Chalan Kareta South Route 10
City/State/Zip	Mangilao, GU 96913-6304

Applicant signature _____ Date _____

Section 2: Fifth Pathway Verification

Institution name _____ Affiliated school _____

Institution name if different when applicant attended _____

Institution address w/country _____

Type of Clinical Rotation	From	To	Weeks Credit
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____

Completed?

☐ Yes. Attendance was from _____ to _____. Completion date was _____.

☐ No. Withdrawal* date was _____. **If the applicant withdrew or was dismissed, please explain below.*

☐ No. Dismissal* date was _____. **If the applicant withdrew or was dismissed, please explain below*

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

Title _____ Date _____

(If no seal is available, this form must be notarized.)

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.