GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

EDDIE BAZA CALVO
GOVERNOR

RAY TENORIO
LIEUTENANT GOVERNOR

JAMES W. GILLAN
DIRECTOR

LEO G. CASIL
DEPUTY DIRECTOR

June 4, 2013

To: Guam Licensed Nurses (RN, APRN, LPN)

From: Executive Officer, Guam Board of Nurse Examiners

Subject: **Renewal Application for Licensed Nurses**

Hafa Adai! On behalf of the Guam Board of Nurse Examiners, the "**Nursing Renewal Application Form**" is now available for download at www.dphss.guam.gov under Forms and Documents, Guam Board of Nurse Examiners Application. This serves as official notification of renewal of licensure to practice nursing on Guam. According to Guam Board of Nurse Examiners Administrative Rules and Regulations, 2007, "Failure to receive renewal notice does not relieve anyone of the responsibility of renewing his/her own license".

This revised 5 page application form is for licensed Nurses who are due for renewal by 9/30/2013. For timely processing of renewal licenses, ensure that completed applications are submitted at least 2 months prior to expiration. Submission of renewal applications will now be accepted during counter services hours from 8:00 AM to 10:30 AM and from 1:00 PM to 3:00 PM Monday through Friday, not including holidays at the new location:

Health Professional Licensing Office
Terlaje Building, Suite 213
194 Hernan Cortez Avenue
Hagatna, Guam 96910

Complete applications may also be mailed to the address above with the following information:

- ✓ 2 recent Passport size photos
- ✓ Guam Nursing Continuing Education Report-see Attachment Form C
  30 hours for Licensed, Registered, and Advanced Practice Registered Nurses
- ✓ Criminal Background Information-Police and Court Clearances-Local and Federal
- ✓ Record of Payment for License Renewal
- ✓ Volunteer Form ESAR-VHP–see attachment (see Public Law 31-146, Emergency Medical Services Act regarding Disaster Teams)
- ✓ Marriage certificate or other official document showing proof of name change
- ✓ Copy of current Certification by a national or state certifying body for APRN's
- ✓ Supporting documents and statements for any "yes" answered questions
- ✓ Complete, Notarized Application

If you have any questions, email marlene.carbullido@dphss.guam.gov. **Si Yu'us Ma'ase.**

Marlene M. Carbullido, RN, MSN

Guam Board of Nurse Examiners
194 Hernan Cortez Avenue, Suite 213
Hagatna, Guam 96910

NURSING RENEWAL APPLICATION FORM

RN_____ APRN_____ LPN_____ C.N.A_____

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

Disciplinary History	
Have any licenses been restricted, revoked, suspended, surrendered, or denied?	YES NO
Have you been disciplined or fined in any of the states licensed?	YES NO
Any pending complaints, charges against you as related to nursing practice?	YES NO
History of Drug or Alcohol Misuse/Abuse/Addictions/Treatments?	YES NO
Any criminal court convictions?	YES NO
Any allegations of unprofessional unethical conduct?	YES NO
I am the subject of a medical malpractice liability claim, settlement, judicial or administrative adjudication case pending or otherwise resolved.	YES NO
Have you ever been fired or told to resign from nursing practice?	YES NO
History of fraud in the procurement of a license or certification?	YES NO
History of Sexual Crime (s) or are you listed on the Sexual Registry?	YES NO
History or Present Physical, Mental, Emotional, Behavioral Conditions that may affect nursing practice?	YES NO
I am delinquent of more than 90 days in child support, spousal support/alimony, or payment of an educational loan.	YES NO

*** Supporting Documents and statements must accompany all "Yes" answers.**

Guam Board of Nurse Examiners
194 Hernan Cortez Avenue, Suite 213
Hagatna, Guam 96910

NURSING RENEWAL APPLICATION FORM

RN_____ APRN_____ LPN_____ C.N.A_____

Certifying Statement:

I certify all information submitted in this application is true and complete to the best of my knowledge and belief and I have the ability to perform within my scope of practice. By virtue of signing this application, I do solemnly swear that I am of good character, free of communicable disease, in good physical and mental health, and I personally completed this form, and the photo is my true likeness.

I authorize the Guam Board of Nurse Examiners, the Health Professional Licensing Office (DPHSS) staff, and their agents to investigate, verify, obtain, release, any and all information provided through personnel files, legal documents, emails, and other forms of communication-written or verbal.

I authorize the release of professional and personal information to individuals, institutions, agencies, and the Data Bank.

I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional competence, personal health, character, ethics, and other qualifications for resolving any doubts of such qualifications.

I understand that knowingly providing false or incomplete information is punishable by fine or imprisonment under United States Code Title 18, Section 1001 and all applicable laws of Guam. If I am a non US citizen, I will provide supporting documentation showing eligibility to work and live in the United States and in the Territory of Guam.

Print Name:
Signature:
Date:

Subscribed and sworn to me this _____day of _____, in

this year_____.

Notary Public_____

Expiration Date: _____

Address/Telephone/Number:_____

(Affix Seal Here)

GUAM BOARD OF NURSE EXAMINERS
Health Professional Licensing Office
Dept. of Public Health & Social Services
123 Chalan Kareta
Mangilao, GU 96913

RECORD OF PAYMENT

IDENTIFICATION

NAME:_____
(LAST) (FIRST) (MIDDLE)

MAILING ADDRESS: _____
(STREET OR P.O. BOX #)

_____
(CITY) (STATE) (ZIP CODE)

SIGNATURE:_____ DATE:_____

II. **VERIFICATION OF CERTIFICATE**
Please print the complete name used on original certification and your social security number
_____ RN LPN CNA APRN SS#_____
Full Name (Print)

III. FEE

All Fees paid are **NON-REFUNDABLE**. All checks, money orders, cashier's checks MUST BE MADE PAYABLE to **"TREASURER OF GUAM". PLEASE CHECK √ YOUR REQUEST(S)**

				NURSE ASSISTANT	
$100.00	RN EXAM	$150.00	RN or PN Continuation of Full approval Fee	$50.00	Nurse Assistant Application for Exam
$100.00	PN EXAM	$150.00	APRN License Application Fee	$ 25.00	Nurse Assistant Endorsement
$100.00	Endorsement	$150.00	APRN Reinstatement of License	$ 40.00	Nurse Assistant Reinstatement
$125.00	Reinstatement for Lapsed or Inactive	$100.00	APRN License Renewal	$ 25.00	Nurse Assistant Certificate Renewal
$ 80.00	RN License Renewal	$ 75.00	APRN Temporary Work Permit	$ 25.00	Certification Verification
$ 60.00	LPN License Renewal	$ 150.00	APRN Prescriptive Authority	$ 20.00	Reissuance of Certificate
$ 25.00	License Verification			$200.00	Nurse Assistant Program Approval Fee
			OTHER		
$ 25.00	Temporary Work Permit (RN, LPN, CNA)	$35.00	Examination Proctoring		
$ 20.00	Reissuance of License	$ 10.00	Nurse Practice Act		
$400.00	RN or PN Nursing Education Program Approval Fee	$ 10.00	Rules and Regulations		
		$ 1.00	Photocopy (Each Page)		

Present this form with your payments at any "TREASURER OF GUAM" locations and return the processed form with receipt(s) to the Board office (GBNE). OFF-ISLAND APPLICANTS: Send this form with your check(s) to GBNE at the above address.

FOR OFFICIAL USE ONLY

Payment: CHECK MONEY ORDER CASH CREDIT CARD
Field Receipt #_____ **Date Paid:**_____

DEPOSIT TO ACCOUNT: 324156344

GUAM BOARD OF NURSE EXAMINERS
Dept. of Public Health & Social Services
123 Chalan Kareta
Mangilao, GU 96913

GUAM NURSING CONTINUING EDUCATION REPORT

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

A. IDENTIFICATION: ( ) Mr. ( ) Miss ( ) Mrs. ( ) Ms.

1. Name:_____
   Last First MI Maiden

2. Email Address: _____Telephone: _____Guam Certificate No:_____

3. Current Employer: _____Position Title: _____

B. Continuing NURSING EDUCATION RECORD:
In compliance with the Nurse Practice Act **(Section 4.10)** the Guam Board of Nurse Examiners will be requiring proof of **30 Contact Hours** related to NURSING or HEALTH seminars/activities.

DATE	TOPIC	ORGANIZER'S NAME	HOURS
		Total Number of Contact Hours Reported:	

I understand that my application will not be accepted for processing until it has been completed in its entirety and I hereby affirm and declare that the above information is true and correct and that any fraudulent entry may be considered cause for rejection or subsequent revocation. It is also understood that the Guam Board of Nurse Examiners may conduct and audit of the registration activities reported on these forms at anytime.

_____ _____
Signature Date

[ATTACHMENT FORM C]

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Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

The ESAR-VHP is a federal program created to support states and territories in establishing standardized volunteer registration program for disasters and public health emergencies. The program, administered on the local level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes. By registering through ESAR-VHP, volunteers, identities, licenses, credentials, accreditations, and hospitals privileges are all verified in advance, saving valuable time in emergency situations. There are significant problems associated with registering and verifying the credentials of health professionals' volunteers immediately after major disasters or emergencies. The loss of telecommunications may prevent contact with sources that provide this privileged information. This program allows organization of qualified professional volunteers. **Please indicate if you are interested in volunteering for the program by signing the authorization for release of information below.**

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (PRINT NAME), hereby authorize GBNE Guam Board of Nurse Examiners Office staff to release the following documentation to GMHA Guam Memorial Hospital which will be needed to verify the identification and clearance for the GMHA EASR-VHP Volunteers Application. The verification and background records will be attained and include the following documents:

1.) Police Clearance
2.) Superior Court Clearance
3.) District Court Clearance
4.) Licensure
5.) Training Certificate (release the following checked items and other when specified)

_____ NRP _____ ACLS _____ NIMS ICS
_____ BLS _____ PALS _____ Other

_____ _____
Signature of Applicant ESAR-VHP Volunteer Date

_____ _____
Witness by GBNE Office Staff Date

Documents released to:

_____ _____
GMHA ESAR-VHP Coordinator Date

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE GMHA PLANNING DEPARTMENT AT 647-2221.

123 CHALAN KARETA, MANGILAO, GUAM 96913-6304
www.dphss.guam.gov • Ph.: 1.671.735.7102 • Fax: 1.671.734.5910