

GUAM BOARD OF NURSE EXAMINERS

Dept. of Public Health & Social Services
123 Chalan Kareta, Mangilao, Guam 96913
Tel: 671-735-7405 thru 671-735-7412

(Please check mark Application):

EXAM Endorsement Reinstatement

IMPORTANT NOTICE: Completion of this application form is necessary for consideration for licensure under the Guam Nurse Practice Act (10 Guam Code Annotated § 12300 et seq.). Failure to disclose all requested information may result in this application not being processed or may result in denial of this application. **All applicants for licensure renewal, endorsement and /or examination have an obligation to update and supplement the information and responses on this application if they change.** Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be **accurate and true**. Please note that the information provided on this application is subject to the public information laws of Guam.

Carefully follow the directions on this application form. In addition, please note the following:

- Type of print legibly with black or blue ink only.
- All fees are NOT refundable. **DO NOT MAKE ANY PAYMENTS IF NO SOCIAL SECURITY NUMBER.**
- Disclosure of your U.S. Social Security number, if you have one, is mandatory. The disclosure is mandated by the Social Security Act. Your social security number will be provided to the Attorney General's Office to assist in the identification of persons who are delinquent in complying with the Child support, spousal support/alimony order or in the repayment of educational loans.
- If the name shown on your supporting documents is different from that shown on your application, you must submit proof of legal name change (e.g., notarized or certified copy of your marriage license, divorce decree, or other court order).
- Answer all questions. If not applicable, indicate N/A.

Submit the following documents and fees:

1. **MUST HAVE U.S. SOCIAL SECURITY NUMBER. APPLICATIONS WILL BE DISAPPROVED WITHOUT A SOCIAL SECURITY NUMBER**
2. Notarized application (all applicants)
3. One passport-size (2x2) photo taken within three months of the date of the application, name printed, signed and dated on the back of the photo (all applicants)
4. Official Transcripts: *Must be sent directly from school to Board office address* (for applicants by Exam, Nurse Assistant Endorsement & APRN Program) **NO HANDCARRIED TRANSCRIPTS WILL BE ACCEPTED**
5. Certification of Education [[Attachment Form A](#)] (for applicants for Exam & Nurse Assistant Endorsement)
6. Verification of Licensure [[Attachment Form B](#)] (for applicants for Endorsement)
7. Verification of last employment – (for Certified Nurse Assistant Endorsement applicants)
8. Criminal background checks: (for all applicants) Police & Court Clearances (State/Federal) dated within two months of the date of the application. **Clearances must be from state of last residence and/or nursing practice.**
9. Notarized copy of current U.S. License/Certification, or APRN National Certification with expiration date (for applicants by Endorsement & Advanced Practice Registered Nurse).
10. Continuing Education hours – [[Attachment Form C](#)] **15** contact hours for Certified Nurse Assistant: **30** – contact hours for Registered Nurse and Licensed Practical Nurse (for renewal and reinstatement applicants).
11. Written explanation for lapsed licenses (for Renewal, Endorsement and Reinstatement applicants).
12. Must submit CGFNS (CES) credentials education report/verification (for **NCLEX** applicants with foreign nursing school programs). Please visit WWW.CGFNS.ORG website for further information
13. Appropriate Fees may be mailed with the application with only U.S. Bank Institution Check or U.S. Postal money order. Handcarried payments must be made directly to any “Treasurer of Guam” cashiers (Public Health-Mangilao, Revenue & Taxation & Dept of Administration) & present the “Record of Payment” form, no payments are accepted at the Board office.
14. **Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Information** [[See Attachment Form D](#)] *This form must be completed with signature.*
- 14). PL29-71, Article 5, §(5.4) Scope of Practice for the APRN shall be in accordance with the functions and standards of the respective national certifying organization for each category. §5.5(a) Any nurse practicing as an (APRN) shall practice in accordance with protocols developed in collaboration with and signed by a physician licensed to practice in Guam. **All application requirements must be received by the GUAM BOARD OF NURSE EXAMINERS office prior to Board’s review during their monthly scheduled meeting.**



Department of Public Health & Social Services
GUAM BOARD OF NURSE EXAMINERS
 123 Chalan Kareta, Mangilao, Guam 96913



LICENSE APPLICATION

Please check appropriate

EXAM Re-EXAM ENDORSEMENT REINSTATEMENT, LICENSE NO. _____

RN LPN CNA APRN Clinical Nurse Specialist Prescriptive Authority:

PART I: APPLICANT INFORMATION

Complete ALL sections on the application form. You must notify the Guam Board of Nurse Examiners, in writing, of any address change(s) after you file this application in order to receive any further notice.

LAST NAME	FIRST NAME	MIDDLE NAME	Suffix	Social Security Number
Mailing Address:				
Residence Address: (How long resided at this address?) _____				
Most recent Employer(s): (List name, address, telephone)				
Position Title and Employment Dates:				
List names used other than stated above (maiden name, surname, aliases, etc.) and reason for change of name:				
Place of Birth (address, city, state, country)			Date of birth: (month/day/year)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Telephone Number:	Home Phone: _____ Work Phone: _____ Cell Phone: _____	Email Address: (Print clearly)		
Emergency Contact: _____ Telephone No: _____ (Last Name, First Name M.I.) Relationship				

1. Citizenship

- a. Are you a United States Citizen? YES NO
- b. If you answered **NO** to question "a" above are you:
 - A qualified alien (as defined in 8 U.S.C.A. §1641)
 - A non-immigrant under the Immigration and Nationality Act (8 U.S.C.A. §1101 et seq)
 - An alien who is paroled into the United States under § 1182(d)(5) for less than one year.
 - A foreign national not physically present in the United States.
 - Other - Please provide detailed explanation.
- c. Do you intend to seek entry into the United States for the purpose of performing labor as a healthcare worker, other than a physician? mark **V** one selection YES NO

PRINT FULL NAME	APPLICANT'S SIGNATURE	DATE
-----------------	-----------------------	------

PART II: EDUCATIONAL INFORMATION

1. Name of Last Secondary School Attended: (High School)	2. Last Secondary School location (City and State/Jurisdiction)	3. Date of Graduation:
		Or Date GED Earned: (Month/Year)
		Jurisdiction where earned:

4. Post Secondary Education History: Starting with your undergraduate education, list all schools, colleges, and universities attended, whether completed or not, in chronological order. Use additional sheets if necessary.

College or University Name	Location (City and State of Country)	Date of Attendance		Graduated? Yes or No If No, give number of credit hours earned	Degree Earned/Major
		From	To		
		MM/DD/YYYY	MM/DD/YYYY		

5. Specialized Training:

List in chronological order from date of graduation to the present all professional post-graduate training not including continuing education coursework (i.e. residency, vocational training, practical of clinical training).

Institutional Name	Location (City and State or Country)	Dates of Attendance		Did you Complete Training? (mark V one)
		From	To	
		MM/DD/YYYY	MM/DD/YYYY	
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No

1. Special Certification:

Have you earned specialized certification? (mark V selection) Yes No

If yes, what type _____ and certification number _____

PRINT FULL NAME	APPLICANT'S SIGNATURE	DATE
-----------------	-----------------------	------

PART III: LICENSURE INFORMATION

If you have ever been licensed, certified or registered to practice in the profession for which you are now making application, or held any other professional license, certification or registration complete the information requested below. You must identify the method by which you obtained your professional license(s), i.e. **(1)** Licensure by examination, **(2)** Score transfer, **(3)** Endorsement, **(4)** Grandfather/waiver provision, or **(5)** Reciprocity – in the appropriate column. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. You must include jurisdictions both within and outside the United States. **Failure to disclose all licenses, certifications or registrations held may result in denial of your application or other appropriate action.**

Jurisdiction	Jurisdiction/ Title of License	License Number/Name on License	How license Obtained(list applicable number from above)	Date of <u>original</u> <u>initial</u> issuance	If License is not current and in good standing, explain below or on a separate sheet
Jurisdiction of Original (Initial) Licensure					
Jurisdiction of Current Licensure where you most recently have been practicing:					
Other Jurisdictions of licensure:					

PART IV: Record of Licensure Examination

If you have ever taken a licensure examination, in any state or territory of the United States, for the profession for which you are now making application, you must complete the information requested below. Each examination attempt may result in the denial of your application or other appropriate action. Use additional sheets if necessary.

Name of Examination Note: If an examination is administered in parts, each part should be listed separately	Jurisdiction	Date of Examination	Passed/Failed/ Other (If Other, please explain)

PRINT FULL NAME	APPLICANT'S SIGNATURE	DATE
-----------------	-----------------------	------

PART V: PERSONAL PRACTICE HISTORY INFORMATION

Please answer each of the following questions by putting a check in the appropriate box on the right. You must answer each question with a “Yes” or “No” response as no other response is acceptable. All “Yes” responses **MUST** be explained in detail in a separate paper signed and dated. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action. **Make selections by marking in one of the following:**

1. Have you ever had any application for any certification or professional license refused or denied by any licensing authority?	<input type="radio"/> Yes <input type="radio"/> No
2. Have you ever been refused or denied the privilege of taking an examination required for any certification or professional licensure?	<input type="radio"/> Yes <input type="radio"/> No
3. Have you ever been dropped, suspended, placed on probation, expelled, fined or requested to resign from any post secondary educational program in which you were enrolled?	<input type="radio"/> Yes <input type="radio"/> No
4. Have you ever been placed on probation, restrictions, suspension, revocation, modification, allowed to resign, requested to leave temporarily or permanently, or otherwise acted against by any certification or professional training program prior to completing the training?	<input type="radio"/> Yes <input type="radio"/> No
5. Have you ever voluntarily surrendered your certificate or license?	<input type="radio"/> Yes <input type="radio"/> No
6. Have you ever allowed a limited license to lapse, issued by any other licensing authority?	<input type="radio"/> Yes <input type="radio"/> No
7. Have you ever voluntarily surrendered any other certification or professional license?	<input type="radio"/> Yes <input type="radio"/> No
8. Have you ever allowed any certification or professional license to lapse?	<input type="radio"/> Yes <input type="radio"/> No
9. Has your certification or professional license ever been revoked?	<input type="radio"/> Yes <input type="radio"/> No
10. Have you ever been the subject of disciplinary action with regard to your certification or professional license, been sanctioned by any licensing authority, association, licensed facility, or staff of such facility?	<input type="radio"/> Yes <input type="radio"/> No
11. Has your privileges ever been restricted or terminated by any licensing authority, association, licensed facility, or staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measure?	<input type="radio"/> Yes <input type="radio"/> No
12. Have you ever had any other certification or professional license revoked?	<input type="radio"/> Yes <input type="radio"/> No
13. Have you ever been the subject of disciplinary action by any licensing agency with regard to any other professional license?	<input type="radio"/> Yes <input type="radio"/> No
14. To your acknowledgment, have any unresolved or pending complaints ever been filed against you with any licensing agency, association, licensed hospital/clinic, or staff of such hospital or clinic?	<input type="radio"/> Yes <input type="radio"/> No
15. Have you ever had a registration issued by a controlled substance authority revoked, suspended surrendered, limited, or restricted?	<input type="radio"/> Yes <input type="radio"/> No
16. Have you ever voluntarily surrendered a registration issued by a controlled substance authority?	<input type="radio"/> Yes <input type="radio"/> No
17. Has your application for accreditation, recertification ever been denied? (i.e. DEA)	<input type="radio"/> Yes <input type="radio"/> No
18. Is there any disciplinary action pending against you by any licensing jurisdiction, the USDA, US Drug Enforcement Agency, or any state drug enforcement authority? If YES, where and when?	<input type="radio"/> Yes <input type="radio"/> No
19. Have you ever been charged with or convicted (including nolo contendere plea or guilty plea) of a felony (or criminal offense) in any state or in federal court (other than minor traffic violations) whether or not a sentence was imposed or suspended? If YES, attach a certified copy of the court records regarding the conviction, the nature of the offense date of discharge, if applicable, as well as a statement from the probation or parole officer.	<input type="radio"/> Yes <input type="radio"/> No
20. Have you ever been pardoned from a felony (or criminal) conviction?	<input type="radio"/> Yes <input type="radio"/> No
21. Have you ever had a record expunged from a felony (or criminal) conviction?	<input type="radio"/> Yes <input type="radio"/> No
22. Are you now or have you in the past five (5) years been addicted to any chemical substance including alcohol? (exclude tobacco and caffeine)	<input type="radio"/> Yes <input type="radio"/> No
23. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, including any disease(s) considered chronic by the medical community, i.e.:1. Mental or emotional disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in practice as a CNA, LPN, RN, APRN?	<input type="radio"/> Yes <input type="radio"/> No
24. Have you ever been named as a defendant to a civil suit related to you profession (i.e. malpractice)?	<input type="radio"/> Yes <input type="radio"/> No
25. Have you ever been court marshaled or discharged other than honorably discharged from the armed forces?	<input type="radio"/> Yes <input type="radio"/> No
26. Have you been terminated from a position with a city, county, state, or federal position?	<input type="radio"/> Yes <input type="radio"/> No

IF THIS IS A RENEWAL APPLICATION, PLEASE ANSWER THE FOLLOWING ADDITIONAL QUESTIONS:

You must check one of the following:

27. Since the date of your last application for renewal of your license, have you been addicted to or used in excess any drug or chemical substance including alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. Since the date of your last application for renewal of your license, have you been treated for a drug or alcohol addiction or participated in a rehabilitation program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
29. Since the date of your last application for renewal of your license, have you had any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, including any disease(s) considered chronic by the medical community, i.e. :1. Mental or emotional disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in practice as a CNA, LPN, RN, APRN?	<input type="checkbox"/> Yes <input type="checkbox"/> No
30. Within the last two (2) years have you had a license or certification revoked or suspended, other disciplinary action taken, or an application for licensure or certification refused, revoked or suspended by any professional licensing authority of another state, territory, or country?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART VI: Child Support/Spousal Support or Alimony/Educational Loan Information:

In accordance with Child Support Public Law: application for renewal of a license, endorsement or a license shall include the applicant’s Social Security number, and the applicant/licensee shall certify, under penalty of perjury, that he or she is not more **90** days delinquent in complying with a child support order, order for spousal support or alimony or educational loan repayment obligation. Failure to certify may result in a disciplinary action, and making a false statement may subject the licensee to contempt of court.

Make selections with in

- I am not more than **90 days** delinquent in complying with: Please mark all that apply
 - a) child support order
 - b) order for spousal support
 - c) alimony
 - d) educational loan repayment obligation.

- I am more than **90 days** delinquent in complying with a child support order/order for spousal support or spousal support or alimony/educational loan repayment obligation. Please mark all that apply
 - a) child support order
 - b) order for spousal support
 - c) alimony
 - d) educational loan repayment obligation.

- I am not currently under any child support order/order for spousal support or alimony/educational loan repayment obligation.

PRINT FULL NAME	APPLICANT’S SIGNATURE	DATE
------------------------	------------------------------	-------------

PART VII: CERTIFYING STATEMENT

“By virtue of filing this Guam Board of Nurse Examiners License Application, I do solemnly swear or affirm that I am of good moral character, and that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge, **and that the photograph attached hereto is a true likeness of myself.**

I hereby authorize the Guam Board of Nurse Examiners to verify any and all information contained in this application, including information maintained in applicable data banks, and transmit this information to the Guam Board of Nurse Examiners.

I authorize the *Guam Board of Nurse Examiners* to review files pertaining to my licensure and practices, and all law enforcement records, administrative records, motor vehicle records, and court documents to confirm the accuracy and completeness of the information provide herein.

This application and signature shall act as authorization of entities in possession of applicable information to release such information to the Guam Board of Nurse Examiners.”

Date

Name of Applicant (Print)

Signature of Applicant

Subscribed and sworn to me this _____ day of _____, 20_____.

(Official Embossed Seal)

Notary Public

GUAM BOARD OF NURSE EXAMINERS

Health Professional Licensing Office
Dept. of Public Health & Social Services
123 Chalan Kareta
Mangilao, Guam 96913

Tel: [\(671\)735-7405](tel:6717357405) thru 735-7412 Fax: (671)735-7413

CERTIFICATE OF NURSING EDUCATION

The applicant below is applying for licensure by examination to practice nursing in Guam. Please complete the following information and **MUST BE SENT DIRECTLY** from School of Nursing to the Guam Board of Nurse Examiners at the address provided above. Official transcripts must be attached.

PART A: TO BE COMPLETED BY APPLICANT

1) CURRENT NAME: _____
(Last) (First) (Middle)

2) PREVIOUS NAME USED: _____
(Last) (First) (Middle)

I HEREBY AUTHORIZE RELEASE OF A COPY OF MY ACADEMIC RECORDS TO THE GUAM BOARD OF NURSE EXAMINERS

Applicant's Signature

Date

PART B: TO BE COMPLETED BY THE NURSING SCHOOL ADMINISTRATOR:

1) NAME OF APPLICANT: _____
(Last) (First) (Middle)

2) SCHOOL OF NURSING: _____
(Name of Nursing Program)
Complete Address: _____

(City) (State/Country) (Zip/ Country Code)

3) Was the school Board-Approved during the applicant's enrollment? Yes No

If Yes, accredited or approved by whom: _____

4) Was applicant a graduate from high school or its equivalent? Yes No

5) The applicant entered the nursing education program on: _____
(Date)

and completed the _____ months program on _____
(Length) (Date)

6) Number of Theory Hours: _____ Number of Clinical Hours: _____

7) Attached is the OFFICIAL copy of applicant's transcripts.

Seal
of
School

Authorized Signature: _____
Print Name: _____
Position Title: _____
Date: _____

[ATTACHMENT A]

GUAM BOARD OF NURSE EXAMINERS

Dept. of Public Health & Social Services
123 Chalan Kareta
Mangilao, Guam 96913

VERIFICATION OF LICENSE

PART I: To be completed by the applicant and forwarded to original state Board of licensure and all appropriate licensing boards. License verification form must be received directly from the State Board of Nursing to Guam Board of Nursing.

ON-LINE LICENSE VERIFICATION IS ACCEPTED ONLY WITH www.NurSys.com (attach online payment receipt)

Name: (Last, First, Middle/Maiden)		Previous Name(s)	
Current Street Address:		City, State, Zip Code	
Date of Birth: (MM/DD/YY)	Social Security Number	Current License Number: Type RN <input type="radio"/> LPN/VN <input type="radio"/>	State
Name as it appears on original license (Last, First, Middle/Maiden)		Original State of Licensure:	
Original License Number <input type="radio"/> RN <input type="radio"/> LPN/VN		Date Issued:	
Nursing Education Program Completed:		Location (City/State)	Graduation Date:
LIST OF ALL OTHER STATES OF LICENSURE State: _____ Lic. No: _____ Date Issued: _____ State: _____ Lic. No: _____ Date Issued: _____ State: _____ Lic. No: _____ Date Issued: _____ State: _____ Lic. No: _____ Date Issued: _____		I hereby authorize all identified Boards of Nursing to release my license data to the _____ Board of Nursing. Signature: _____ Date: _____	

PART II: To be completed by licensing board and forwarded to Board of Nursing listed at the top of this form.

This is to certify that the above named individual was issued license number _____ Date Issued _____ to practice:

RN LPN/Vocational Nurse

Licensed by: <input type="radio"/> Examination <input type="radio"/> Endorsement <input type="radio"/> Waiver	Current License Status: <input type="radio"/> Active <input type="radio"/> Inactive Expiration Date: _____
---	---

Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited placed on probation)? Yes No

Disciplinary Action Pending? Yes No (Explain Yes responses on the reverse side)→→→→→

Nursing Education Program Completed: Location (City/State)	Approved by State? <input type="radio"/> Yes <input type="radio"/> No	Graduated From: <input type="radio"/> High School <input type="radio"/> High School Equivalency <input type="radio"/> Completion of 10 th Grade
	Graduation Date	

STATE BOARD TEST POOL EXAMINATION					LPN/VN	NCLEX LPN/VN	
Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children		RN	
Score							
Series/ Form #							

Number of times applicant wrote exam: _____ Dates _____ Exam in English? YES NO

Signature: _____

(BOARD SEAL)

Title: _____

State: _____ Date _____

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

The Emergency System for Advance Registration of Volunteer Health Professionals (**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.

Why does Guam need ESAR-VHP?

In the wake of disasters and public health emergencies, many of our nation's health professionals are eager and willing to volunteer their services. And in these times of crisis, hospitals, clinics, and temporary shelters are dependent upon the services of health professional volunteers. However, on such short notice, taking advantage of volunteers' time and capabilities presents a major challenge to hospital, public health, and emergency response officials.

For example, immediately after the attacks on September 11, 2001, tens of thousands of people traveled to ground zero in New York City to volunteer and provide medical assistance. In most cases, authorities were unable to distinguish those who were qualified from those who were not, no matter how well intentioned.

There are significant problems associated with registering and verifying the credentials of health professionals volunteers immediately following major disasters or emergencies. Specifically, hospitals and other facilities may be unable to verify basic licensing or credentialing information, including training, skills, competencies, and employment. Further, the loss of telecommunications may prevent contact with sources that provide credential or privileges information.

The goal of the ESAR-VHP program is to eliminate a number of the problems that arise when mobilizing health professional volunteers in an emergency response.

Please indicate if you are interested in the program and would like more information about registering as a volunteer by making the box with a ✓:

YES, I am interested to receive more information about ESAR-VHP.

NO, I am not interested.

PRINT FULL NAME

APPLICANT'S SIGNATURE

DATE

GUAM BOARD OF NURSE EXAMINERS

Dept. of Public Health & Social Services
123 Chalan Kareta
Mangilao, GU 96913

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (PRINT NAME), hereby authorize Guam Board of Nurse Examiners Office staff to release the following documentation to Guam Memorial Hospital Agency (GMHA) 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 HPLO/EMS Personnel:

Date

Documents released to:

GMHA ESAR-VHP Coordinator

Date

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