AGENCY/ON-ISLAND ADOPTION CHECK-LIST

- ▫ Application and Questionnaire (Bossa form available)
- ▫ Birth Certificate of Petitioner(s)/Applicant(s)
- ▫ Marriage Certificate
- ▫ Divorce Decrees (if any)
- ▫ Verification of Employment (Bossa form available)
- ▫ Physical Examination / Medical history report for Petitioners (Bossa form available)
- ▫ Signed Consent for release of information to conduct CPS Registry/Background Check (Bossa form available)
- ▫ Police Clearance for Petitioner(s)
- ▫ Two character reference (Bossa form available/letters accepted)

PRINT

Download

Clear Form

DEPT. OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES
GOVERNMENT OF GUAM
P.O. BOX 2816
AGANA, GUAM 96910
TELEPHONE: 477-8907

FOR OFFICE USE
Date Rec'd: _____
By: _____

ADOPTION APPLICATION

	MALE	FEMALE
NAME	_____ LAST FIRST MIDDLE	_____ MAIDEN FIRST MIDDLE
ADDRESS (RESIDENTIAL)	_____ NUMBER/STREET _____ CITY/VILLAGE STATE ZIP CODE WORK PHONE: _____ HOME PHONE: _____	_____ NUMBER/STREET _____ CITY/VILLAGE STATE ZIP CODE WORK PHONE: _____ HOME PHONE: _____
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	_____ BOX NUMBER _____ CITY/VILLAGE STATE ZIP CODE	_____ BOX NUMBER _____ CITY/VILLAGE STATE ZIP CODE
BIRTHDATE/ BIRTH PLACE SOCIAL SECURITY NO.	_____ _____ _____	_____ _____ _____
ETHNIC / RACE ORIGIN	____ ORIENTAL ____ HISPANIC ____ BLACK ____ MIXED ____ CAUCASIAN OTHER: _____ ____ CHAMORRO	____ ORIENTAL ____ HISPANIC ____ BLACK ____ MIXED ____ CAUCASIAN OTHER: _____ ____ CHAMORRO
RELIGIOUS AFFILIATION		
PRESENT MARRIAGE	DATE: _____ PLACE: _____	
SINGLE APPLICANT?	____ YES ____ NO	
PREVIOUS MARRIAGE (IF APPLICABLE)	DATE: _____ PLACE: _____ HOW TERMINATED: _____	DATE: _____ PLACE: _____ HOW TERMINATED: _____
EDUCATION (STATE HIGHEST LEVEL COMPLETED AND NAME OF SCHOOL) DEGREE AWARDED (IF APPLICABLE)	_____ _____ _____	_____ _____ _____
CURRENT EMPLOYMENT	PLACE: _____ DATE OF HIRE: _____ SALARY/PER ANNUM: _____ SUPERVISOR: _____	PLACE: _____ DATE OF HIRE: _____ SALARY/PER ANNUM: _____ SUPERVISOR: _____
LIFE INSURANCE	COMPANY: _____ COVERAGE: _____	COMPANY: _____ COVERAGE: _____
HEALTH INSURANCE	COMPANY: _____ COVERAGE: _____	COMPANY: _____ COVERAGE: _____

(CONTINUED ON REVERSE SIDE)

CHILDREN (IN AND OUT OF HOUSEHOLD)

NAME	DOB	SEX	NATURAL/ADOPTED	SCHOOL/OCCUPATION

ALL OTHERS IN HOUSEHOLD

NAME	AGE	RELATIONSHIP	OCCUPATION

HOME OWN ____ RENT ____ MILITARY HOUSING ____ NO OF BEDROOMS _____

REFERENCES (LOCAL)

NAME	MAILING ADDRESS/PHONE
1.	
2.	
3.	

RELATIVES IN CLOSE TOUCH WITH FAMILY

NAME	MAILING ADDRESS	RELATION
1.		
2.		

DETAILS OF CHILD DESIRED

AGE: _____ SEX: _____

PLEASE CIRCLE WHAT YOU WILL ACCEPT:

ETHNIC ORIGIN/RACE: ORIENTAL, BLACK, CAUCASIAN, CHAMORRO, HISPANIC, MIXED, OTHER: _____

HANDICAPPED: PHYSICAL - MINOR, MODERATE, SEVERE
MENTAL - MINOR, MODERATE, SEVERE
NO HANDICAPPED

SIBLING GROUP:

IF WILLING TO ADOPT MORE THAN ONE CHILD, HOW MANY? _____

MOTIVATION FOR ADOPTION

PLEASE EXPLAIN: _____

IF CHILDLESS, IS REASON MEDICAL? _____

HAS IT BEEN CONFIRMED? _____

OTHER COMMENTS

OTHER ADOPTION APPLICATIONS

IF YOU HAVE APPLIED OR ARE APPLYING NOW TO ADOPT ELSEWHERE, PLEASE INDICATE DATE AND PLACE: _____

REASON FOR NON-COMPLETION OF ADOPTION _____

LENGTH OF TIME ON GUAM

HOW LONG DO YOU EXPECT TO BE ON GUAM? _____

MILITARY APPLICANTS: TOUR OF DUTY EXPIRES ON: _____

ARE YOU WILLING TO EXTEND IF NECESSARY? _____

(PLEASE NOTE THAT PUBLIC LAW 13-133 REQUIRES A 12-MONTH RESIDENCY OF THE CHILD AFTER PLACEMENT PRIOR TO ADOPTION.)

I UNDERSTAND THAT THIS APPLICATION EXPIRES IN ONE YEAR AND MUST BE RENEWED IN ORDER TO BE CONSIDERED. (IF MARRIED, BOTH SPOUSES MUST SIGN APPLICATION.)

_____ _____
APPLICANT'S SIGNATURE DATE

_____ _____
APPLICANT'S SIGNATURE DATE

FOR OFFICE USE ONLY

AGENCY CONTACTS WITH APPLICANT(S):

ADOPTION QUESTIONNAIRE
for Male Adoption

MARRIAGE: A. 1st ( ) B. 2nd ( )

MARITAL RELATIONSHIP:

CHILDREN: A. OWN ( ) B. ADOPTED ( )

REASON FOR INSTIGATION OF ADOPTION:

TYPE OF CHILD DESIRED:

HISTORY OF MALE APPLICANT:

1. FAMILY BACKGROUND:

2. H. S. EDUCATION, COLLEGE:

3. EMPLOYMENT:

4. ACTIVITY:

ADOPTION QUESTIONNAIRE
FOR Female Applicant

MARRIAGE: A. 1st ( ) B. 2nd ( )

MARITAL RELATIONSHIP:

CHILDREN: A. OWN ( ) B. ADOPTED ( )

REASON FOR INSTIGATION OF ADOPTION:

TYPE OF CHILD DESIRED:

HISTORY OF FEMALE APPLICANT:

1. FAMILY BACKGROUND:

2. H.S. EDUCATION, COLLEGE:

3. EMPLOYMENT:

4. ACTIVITY:

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
P. O. BOX 2816
AGANA, GUAM 96910

EMPLOYMENT VERIFICATION

Name: _____

Employer: _____

Hire Date: _____

Position: _____

Employment Status: _____

Salary: _____

Dates Paid: _____

_____

_____

_____

By: _____ Date: _____

AUTHORIZED SIGNATURE

To: PERSONNEL DEPARTMENT

YOU ARE HEREBY AUTHORIZED TO RELEASE THE ABOVE REQUESTED INFORMATION TO THE DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES.

_____

SIGNATURE OF EMPLOYEE Date: _____

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
P. O. BOX 2816
AGANA, GUAM 96910

EMPLOYMENT VERIFICATION

Name: _____

Employer: _____

Hire Date: _____

Position: _____

Employment Status: _____

Salary: _____

Dates Paid: _____

_____

_____

_____

By: _____ Date: _____

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SIGNATURE OF EMPLOYEE Date: _____

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
GOVERNMENT OF GUAM
HAGÅTÑA, GUAM

REPORT OF MEDICAL HISTORY

NAME:	SEX:	MARITAL STATUS:
DATE OF BIRTH:	PLACE OF BIRTH:	CITIZENSHIP:

***Please complete this form and take it with you to your Physician for examination.**

Example

Family Member	Age	State of Health	Age at Death	Cause of Death	Ailment	YES	NO	Relationship
FATHER	55	Fair	N/A	N/A	TUBERCULOSIS			
MOTHER	45	Good	N/A	N/A	DIABETES	✓		Father

Family Member	Age	State of Health	Age at Death	Cause of Death	Ailment	YES	NO	Relationship
FATHER					TUBERCULOSIS			
MOTHER					DIABETES			
BROTHER (S)					ARTHRITIS			
					EPILEPSY			
					CONVULSIONS			
					HEART DISEASE			
					KIDNEY DISEASE			
SISTER (S)					HIGH BLOOD PRESSURE			
					STOMACH AILMENT			
					ASTHMA HAY FEVER			
					OTHER DISEASE (S)			

PERSONAL HISTORY

Have any of your family members or relatives ever had any of the following ailments?
Please indicate **YES** or **NO** in all questions. Make appropriate comments in the space provided below or on a separate sheet of paper.

Have you ever had....	YES	NO	Have you ever had....	YES	NO	Have you ever had....	YES	NO
SCARLET FEVER			CHEST PAINS			INSOMNIA (can't sleep)		
RHEUMATIC FEVER			SHORTNESS OF BREATH			ANXIETY DISORDER		
MEASLES			ASTHMA			DEPRESSION		
GERMAN MEASLES			HAY FEVER			NERVOUSNESS		
MUMPS			ALLERGY			STOMACH TROUBLE		
CHICKEN POX			TUBERCULOSIS			DIARRHEA		
MALARIA			TUMOR OR CANCER			DIZZINESS FAINTNESS		
RECENT GAIN OR WEIGHT LOSS			JAUNDICE			PALPITATION		
ANY SURGERY			DIABETES			HEADACHES		
ARTHRITIS			EPILEPSY			COLDS/SORE THROAT		
CONVULSIONS			HEART DISEASE			KIDNEY DISEASE		
KIDNEY DISEASE			HIGH BLOOD PRESSURE			STOMACH AILMENT		
OTHER:			OTHER:			OTHER:		

PHYSICIAN'S CERTIFICATION

Based on my examination of: _____
NAME

I Certify that this person is ❑ Free from infectious disease and in good health ❑ Temporarily ❑ Permanently
❑ In poor health but able to maintain employment ❑ Temporarily ❑ Permanently
❑ In poor health and unable to maintain employment ❑ Temporarily ❑ Permanently

ACTIVITIES TO BE AVOIDED: ❑ Lifting ❑ Pushing ❑ Standing ❑ Climbing ❑ Walking ❑ Other:_____

_____ _____ _____
PHYSICIAN'S SIGNATURE **CLINIC/HOSPITAL** **DATE**

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
GOVERNMENT OF GUAM
HAGÅTÑA, GUAM

REPORT OF MEDICAL HISTORY

NAME:	SEX:	MARITAL STATUS:
DATE OF BIRTH:	PLACE OF BIRTH:	CITIZENSHIP:

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MOTHER					DIABETES			
BROTHER (S)					ARTHRITIS			
					EPILEPSY			
					CONVULSIONS			
					HEART DISEASE			
					KIDNEY DISEASE			
SISTER (S)					HIGH BLOOD PRESSURE			
					STOMACH AILMENT			
					ASTHMA HAY FEVER			
					OTHER DISEASE (S)			

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MUMPS			ALLERGY			STOMACH TROUBLE		
CHICKEN POX			TUBERCULOSIS			DIARRHEA		
MALARIA			TUMOR OR CANCER			DIZZINESS FAINTNESS		
RECENT GAIN OR WEIGHT LOSS			JAUNDICE			PALPITATION		
ANY SURGERY			DIABETES			HEADACHES		
ARTHRITIS			EPILEPSY			COLDS/SORE THROAT		
CONVULSIONS			HEART DISEASE			KIDNEY DISEASE		
KIDNEY DISEASE			HIGH BLOOD PRESSURE			STOMACH AILMENT		
OTHER:			OTHER:			OTHER:		

PHYSICIAN'S CERTIFICATION

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❑ In poor health but able to maintain employment ❑ Temporarily ❑ Permanently
❑ In poor health and unable to maintain employment ❑ Temporarily ❑ Permanently

ACTIVITIES TO BE AVOIDED: ❑ Lifting ❑ Pushing ❑ Standing ❑ Climbing ❑ Walking ❑ Other:_____

_____ _____ _____
PHYSICIAN'S SIGNATURE **CLINIC/HOSPITAL** **DATE**