

GUAM BOARD OF MEDICAL EXAMINERS

Guam Board of Medical Examiners Regular Board Meeting

Wednesday, January 14, 2026 at 4:00 pm RECONVENED Wednesday, January 28, 2026

194 Hernan Cortez Ave. Terlaje Professional Bldg., Suite 209, Hagåtña, GU 96910

Join Zoom Meeting:

<https://us06web.zoom.us/j/84987496898?pwd=AB1QfXp2LeeqLFmFVmNzPa1Z2vABiZ.1>

Meeting ID: 849 8749 6898 Passcode: 851816

MINUTES

Topic	DECISION(S) / ACTION(S) MADE	Responsible Party	Time	Status
I. Call to Order	Meeting Chaired by: Dr. Berg	Chair	1603	Called to Order
	A. Roll Call: GBME <u>Present</u> <input checked="" type="checkbox"/> Nathaniel B. Berg, M.D., Chairperson <input checked="" type="checkbox"/> Sungwook "Steve" Kim, Podiatry Member <u>Virtually Present:</u> <input checked="" type="checkbox"/> Luis G. Cruz, M.D., Secretary <input checked="" type="checkbox"/> Joleen Aguon, M.D., Vice Chairperson <input checked="" type="checkbox"/> Alexander D Wielaard, M.D., Treasurer <input type="checkbox"/> Ricardo Eusebio, M.D., Member of GMHA <input type="checkbox"/> Ray Tajalle, Physician Assistant Member	Chair		Quorum Established
	B. Confirmation of Public Notice: 01/07/2026 and 01/12/2026 Dr. Berg reviewed and found it to be in conformance with current laws.			Confirmed
	C. Election of Board Officers: The board discussed the upcoming election of officers and agreed to postpone the election until the anticipated confirmation and return of Dr. Bordallo, citing her prior experience as a long-standing board member and the importance of full participation in officer selection, and after confirming consensus among the members present, the board collectively agreed to keep the current officers in place until the next meeting. <i>Motion to Table Until Next Month: Dr. Berg.</i>	Chair		Tabled. Until Next Meeting
II. Adoption of Agenda	<i>Motion to Adopt the Agenda: Dr. Berg.</i>	GBME		Adopted
III. Review and Approval of Minutes	Draft Minutes dated December 10, 2025 <i>Motion to Approve: Dr. Berg.</i>	GBME		Unanimously Approved
IV. Treasurer's Report	No report	Dr. Wielaard		No Report

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V.	<p data-bbox="184 240 346 344">HPLO Administrator's Report</p> <p data-bbox="394 240 1627 587">B. Sablan reported updates, including notification that the Office of Technology approved the request for official board email accounts under the gbme.guam.gov domain, with forms distributed to members for account creation, and appreciation was expressed to Dr. Berg and the board for hosting the FSMB team in early January, during which best practices were discussed with an emphasis on jurisdictional screening, prioritization of complaints, and administrative delegation to better focus board resources on issues of clinical competence and professional ethics. Additionally, the board was informed that a fast-track complaint model is being explored for cases involving unlicensed practitioners and matters posing imminent harm, such as sexual misconduct or substance abuse, and consideration was suggested for handling certain straightforward complaints at the administrative level pursuant to recently delegated authority, while clarifying for the record that the board currently has eight open complaints, including three newly received cases to be addressed at a future meeting.</p> <p data-bbox="394 620 1606 771">Dr. Berg respectfully disagreed with the senator's characterization of the complaint count, clarifying that the board currently has five active cases under review, while three recently received matters cannot yet be adjudicated, and emphasized the need to investigate the source of the publicly stated and inaccurate claim that the board had 80 cases, noting that such misinformation should not be directed at the board and expressing optimism that the five active cases would be resolved in a timely manner.</p>	HPLO		Noted
VI.	<p data-bbox="157 782 373 803">Chairperson's Report</p> <p data-bbox="394 782 1627 912">(a) Bill 206-38 (COR) An Act to Add a New §12202 (c), Amend §12205 (c), §12206 and Add a New 12206.1 AND §12207 (a) (5) To Article 2, Chapter 12, Title 10, Guam Code Annotated, Relative to Building a More Diverse and Sustainable Healthcare Workforce on Guam by Expanding Licensure Pathways for Foreign medical Graduates and Establishing a Local CONRAD 30 J-1 Physician Waiver Program.:</p> <p data-bbox="394 917 1627 1286">The board was informed that the recent meeting with the FSMB was highly productive and that members were encouraged to make travel arrangements to attend upcoming FSMB meetings, as the collaboration has been beneficial and positively received, and it was reported that work is currently underway on proposed legislation addressing the licensing of internationally trained physicians, in coordination with the FSMB, the Massachusetts board, and the North Carolina board, with input from Dr. Eusebio and at the request of both the legislature and executive leadership, and that while no vote will be taken due to the legislative nature of the matter, the full board's feedback will be sought once draft materials are circulated. Additionally, Dr. Berg noted that a future proposal under consideration, but not yet ready for action, involves the possible creation of a separate board for advanced practice nurses modeled after North Carolina's structure, which would divide oversight responsibilities between medical and nursing matters, and that this concept will be revisited after completion of the internationally trained physician initiative.</p>	Dr. Berg		Noted
VIII	A. Complaint(s):			

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	<p>1. GBME-CO-20-005 – Received: 09/18/2020</p> <p>Dr. Cruz explained that the case had been transferred from prior investigators and that a previous investigator sought a legal opinion regarding how to handle an outside medical expert’s opinion, after which the Attorney General advised that such an expert opinion should be treated as evidence, due process must be afforded to all parties, and the ultimate decision to accept or decline the opinion rests with the Board. He further clarified that legal guidance had also been sought previously due to the complainant’s past litigation involving the Board, and that the current objective was to determine whether the Board could now proceed with the case through its standard process.</p> <p>Dr. Cruz summarized that the complainant alleged a GMH physician failed to meet the standard of care and requested an impartial review of events at GMH, that the physician denied fault through legal counsel, that GMH reached a \$200,000 settlement, and that the complainant continued to dispute the response and requested an off-island investigation while providing video evidence. It was noted that an off-island medical expert conducted a thorough review and concluded that the physician did not meet the standard of care, and the investigator ultimately recommended that the Board accept the expert opinion and consider imposing restrictions or pursuing mediation with the physician.</p> <p>Dr. Berg inquired whether the physician should be required to undergo a professional evaluation through a continuous professional evaluation program, noting that the Board has previously required physicians, at their own expense, to participate in such programs when an opinion has been rendered that the standard of care was not met. The board member referenced the PACE program commonly recommended by the FSMB for single-incident cases and suggested that, given the circumstances and the apparent isolated nature of the incident in the physician’s career, this option be considered as a potential course of action.</p> <p>Discussion continued regarding the potential use of a PACE program, with questions raised by Dr. Cruz about what options such programs offer and whether GMH had imposed any restrictions, limitations, or remedial requirements on the physician’s practice following the findings. Dr. Aguon could not give immediate confirmation as to whether any corrective or disciplinary actions had been taken by GMH and she noted that this information would need to be verified with the Medical Executive Committee. Board members agreed that understanding any prior actions taken by GMH was pertinent to the Board’s deliberations. Dr. Aguon sought clarification regarding Dr. Cruz’s role as the investigator, specifically whether he was expected to recommend potential actions to the Board or</p>	Dr. Cruz		On-Going, Tabled Until Next Meeting

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	<p>solely to present findings, with the understanding that final determinations regarding appropriate actions rest with the Board.</p> <p>Dr. Berg explained that when an investigator concludes the physician did not meet the standard of care, the investigator may either make a recommendation or refer the matter to the Board for collective discussion and determination of appropriate action. Dr. Berg expressed a preference for utilizing PACE programs, noting that such programs allow qualified experts to determine whether the conduct reflects an isolated incident or a broader pattern of practice, an assessment the Board itself may not be equipped to make. Dr. Berg further stated that while the Board has an expert opinion regarding the specific incident, obtaining an independent professional evaluation would assist in determining the physician's overall competency, patient safety considerations, and any identified practice deficiencies, and that these programs are viewed as valuable resources to support informed Board decision-making.</p> <p>Dr. Cruz expressed agreement with the use of a PACE program and recommended it if the physician is agreeable, while noting that, consistent with guidance from the Attorney General, the physician must be afforded due process, including the opportunity to review the expert opinion and indicate whether it is accepted or disputed. Dr. Berg emphasized that while due process is required, the Board ultimately has the authority to decide whether to require participation in such a program, and expressed the view that requiring an evaluation would align with the Board's mission to protect the public, particularly given that the case involved a patient death and uncertainty as to whether the incident was isolated. The discussion further clarified that the Board may vote to require participation in the evaluation program, allow the physician to submit an appeal for the investigator's review, and determine whether additional investigation is warranted, while also recognizing the physician's right to request a formal hearing within the prescribed timeframe, after which the Board could render a decision informed by the evaluation results or hearing outcome.</p> <p>Dr. Aguon, Dr. Berg and Dr. Cruz discussed that the matter under consideration was a long-standing, high-profile case and sought clarification on the current stage of deliberations, specifically regarding the Board's potential actions and Dr. Cruz's recommendations. It was acknowledged that some members were not fully familiar with the detailed facts of the case, but understood that the matter had been reviewed by an off-island medical expert with a Med-Peds background who was selected for familiarity with both regional and local standards of care.</p> <p>Dr. Berg provided clarification that the case had been delayed not due to the absence of an expert</p>			

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	<p>opinion, but because a prior investigator sought legal guidance on how to proceed in light of the expert findings and prior legal issues involving the complainant, and that the Attorney General subsequently advised that the Board could move forward provided due process and the opportunity for a fair hearing were afforded if requested.</p> <p>Dr. Cruz summarized the current posture of the case by stating that an off-island expert had conducted a detailed review and concluded that the standard of care was not met, after which the matter was delayed while legal guidance was sought on how to proceed with adjudication. It was noted that the Attorney General has since advised that the Board may move forward with adjudication, with the understanding that a hearing would be available if an appeal is raised. Dr. Cruz further explained that under Guam law the Board has several different disciplinary and remedial options available, from reprimand or censure to suspension or revocation of licensure, as well as the ability to require additional training or competency assessments, such as participation in a PACE program, as part of its determination.</p> <p>Dr. Berg noted that it has become standard practice for many medical boards to utilize organizations that evaluate physicians, with the most recognized being the one in San Diego, and others in Ohio, Philadelphia, and Texas also frequently used. The discussion then focused on a specific case in which a physician's isolated mistake resulted in a patient death. Dr. Cruz emphasized that while humans are fallible and one-time errors do not necessarily indicate gross negligence, it is important to determine whether the incident was isolated or indicative of a larger competency concern. Dr. Berg clarified that the recommendation for assessment is not a judgment of the physician's overall competence but rather a responsibility to the public to ensure that the adverse outcome was an isolated event, noting that such organizations routinely conduct competency evaluations in cases of rare but serious incidents.</p> <p>Dr. Cruz emphasized that the most effective way to protect the public is by improving healthcare systems rather than focusing solely on individual errors, noting that the board could advocate for system changes at the facility where the incident occurred to prevent future harm. Dr. Berg agreed and acknowledged this perspective but clarified that the board's responsibility is to evaluate the behavior of its licensees, not the operations of hospitals or clinics, and that the board's role is to assess the physician in relation to the incident that resulted in a patient's death. Dr. Cruz then addressed the potential value of a formal competency evaluation, with the board noting that such assessments can identify subtle patterns in a practitioner's performance even in the absence of complaints and provide</p>			

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	<p>detailed reports with recommendations ranging from no deficits to significant deficits, which can inform decisions to enhance public safety.</p> <p>Dr. Kim noted that, in addition to PACE, the FSMB offers another program called CPEP, which is generally intended for evaluation following a single adverse event, Dr. Berg acknowledged that while the acronyms are sometimes confused, the underlying purpose of both programs is the same: to provide an objective professional assessment based on individual or multiple incidents. It was noted that Dr. Cruz and the board would review the programs and determine which is best suited for the specific case, ensuring that any prior evaluations by the hospital are considered to avoid redundancy or double discipline. Dr. Berg emphasized that the process is not punitive but a structured next step to evaluate the physician's performance, typically completed within approximately 60 days, allowing for flexibility as needed. Following the evaluation, Dr. Cruz, as the investigator would assess the findings and make recommendations regarding whether the incident was isolated or if further education or intervention is warranted, with the ultimate goal of protecting public safety in collaboration with the hospital.</p> <p>Dr. Aguon asked whether the details of the case would be reviewed or if the board would rely solely on the expert opinion provided and inquired if the case had been discussed in prior meetings. Dr. Berg clarified that the board had previously reviewed the expert opinion and agreed there was no disagreement, but the question remained whether the investigator could proceed based on that opinion, then the investigator left with the case subsequently being assigned to Dr. Cruz pending authorization from the Attorney General. Dr. Cruz emphasized that while confidentiality must be maintained, understanding the severity of the deviation from the standard of care is important, as it can range from a difficult clinical judgment to a more egregious error, and that the type of action the board might take depends on this context. Dr. Berg noted that the expert had determined a significant deviation from the standard of care occurred, resulting in the death of a child, and the board expressed that while a single incident should not ordinarily define a physician's career, in this case there is an obligation to ensure the physician undergoes a professional evaluation to determine whether the incident was isolated. The discussion focused on determining the appropriate disciplinary action for a situation that appeared to involve either a minor procedural oversight or a more serious professional lapse. Dr. Cruz suggested that if the issue was relatively basic and procedural, it might warrant additional training, but if it extended beyond that, a formal censure or reprimand would be more appropriate, emphasizing the seriousness with which the board treats such matters. Dr. Berg noted that some form of punitive action was likely, though the board was not yet prepared to decide, and proposed that an expert evaluation of</p>			

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	<p>the individual's general competence be obtained and shared with all board members. The evaluation would then be reviewed in context before the board determined whether the incident warranted censure, suspension, additional education, or another corrective measure, even if it were an isolated occurrence. The board discussed the appropriateness of issuing a censure in cases involving serious deviations from the standard of care. Dr. Aguon emphasized that if the incident caused harm or death and represented a significant departure from accepted practice, a censure would be justified regardless of whether the event was isolated, highlighting the board's responsibility to prevent future occurrences. Dr. Berg agreed, suggesting that both a formal disciplinary action and a thorough evaluation of the individual should be pursued simultaneously, acknowledging that even a single serious incident could warrant censure while still obtaining additional assessment to inform further decisions.</p> <p>Dr. Cruz agreed that if the incident represented a significant deviation from the standard of care, it warranted a formal reprimand or censure to clearly communicate the seriousness of the issue to the licensee and to emphasize that any recurrence would be treated with extreme concern. Dr. Cruz noted that, given the time elapsed since the original complaint in 2020 and the board's relatively recent composition, the board should carefully review all medical records and the expert opinion before making a final determination. Consensus emerged that the case justified both formal disciplinary action and further evaluation of the individual's practice, with Dr. Cruz tasked with preparing the appropriate censure letter on behalf of the board.</p> <p>Dr. Berg proposed a motion noting that an expert opinion had determined a deviation from the standard of care that ultimately resulted in the death of a child, and upon acceptance of this opinion, recommended that the investigating officer produce a written censure to the physician, requiring the physician to educate him or herself and submit a plan to the board addressing the issues involved. Additionally, Dr. Berg suggested that the physician be required to attend a professional evaluation program at the discretion of the investigating officer.</p> <p>Dr. Cruz stated that the authority to issue the censure and determine any related requirements should rest with the board rather than the investigating officer, and further expressed concern that the case should have been adjudicated much earlier.</p> <p>Dr. Wielaard stated that the proposed approach would be fair to Dr. Cruz and emphasized that a specific action should be formally proposed so the board could vote on it. It was further noted that the</p>			

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	<p>board needed to clearly understand the distinctions between a formal warning, a reprimand, and a censure to determine the most appropriate level of discipline. Dr. Wielaard suggested that board members may need to review the case further and be prepared to vote at the next meeting, as the board would be responsible for deciding the appropriate disciplinary action.</p> <p>Dr. Aguon requested a list of available disciplinary options, noting that any action taken would likely involve a combination of measures rather than a single sanction.</p> <p>Dr. Berg clarified that while censure and remediation had been discussed, the board preferred to allow an additional month to review the case and receive formal definitions from the administrator regarding the differences between a reprimand, censure, and other possible actions. This additional time would also allow Dr. Cruz and board members to review available programs and disciplinary options. Dr. Berg emphasized that no vote would be taken at the current meeting, that the matter would be placed back on the agenda for the following month, and that the recommendation was to allow all members adequate time to review the case thoroughly before making a final decision.</p> <p>Dr. Wielaard indicated agreement with the general approach but noted the need to leave the meeting due to time constraints, while emphasizing the importance of the discussion. It was stated that the board would need to reach a decision and that a more comprehensive competency evaluation was being considered to identify any potentially concerning practice patterns, with the understanding that any initial proposal would be a recommendation subject to collective review and refinement by the board.</p> <p>Dr. Aguon expressed that responsibility for determining appropriate actions should not rest solely with the investigator or Dr. Cruz, but should instead be shared by the full board. Dr. Aguon recommended that the board's administrative support compile and present information on available disciplinary and remediation programs to the Guam Board of Medical Examiners.</p> <p>Dr. Berg stated a willingness to assist in ensuring that all board members clearly understood the available program options and agreed to work with the administrator to present those options to the board. Dr. Berg requested that the expert opinion and related complaint be distributed to all board members for review, and B. Sablan confirmed that the complaint, expert opinion, discipline matrix, standard operating procedures, and definitions of disciplinary actions would be provided to clarify the process and current stage of the case. Dr. Berg emphasized that while Dr. Cruz had already expressed acceptance of the expert opinion, the determination of next steps remained a collective board decision requiring a formal vote, and that the case would be continued one final time before a decision was made. Dr. Berg also directed that the complainants be informed that a decision on the next course of action would be made at the next meeting, and Dr. Cruz requested additional information regarding</p>			

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	<p>whether GMH had taken any disciplinary action, Dr. Aguon agreed to obtain and report that information. <i>Motion to Table to Next Meeting: Dr. Berg.</i></p>			
	<p>2. GBME-CO-2022-010 – Received: 06/21/2022 Dr. Berg noted this case is currently pending review by the Office of the Attorney General for a formal opinion, and it was reported B. Sablan anticipates receiving a response within approximately one month.</p>	Dr. Aguon		On-Going, Awaiting Response within a Month
	<p>3. GBME-CO-2025-003 – Received: 06/12/2025 Dr. Berg discussed this complex complaint involving a physician who did not renew a Guam license while under investigation for allegations related to inadequate patient evaluation through the VA, noting that because the license expired and was not renewed, the physician is no longer under the board’s jurisdiction, resulting in dismissal of the case with the condition that it would be immediately reopened should the physician reapply for licensure in Guam. Dr. Berg further reported that the complaint was forwarded to other jurisdictions where the physician holds licensure to notify them of the unresolved investigation, and that the complainant would be personally informed of the jurisdictional limitations and advised on how to pursue the matter in other states, such as California, where the physician is licensed, while clarifying that VA and military physicians on Guam are not required to hold a Guam license so long as they are actively licensed in another U.S. jurisdiction.</p>	Dr. Berg		On-Going
	<p>4. GBME-CO-2025-004 – Received: 06/12/2025 Dr. Berg explained this case involved a licensed cosmetologist and noted that the matter was forwarded to the Board of Cosmetology for adjudication and that the board will await the outcome of their review.</p>	GBME		On-Going, Awaiting Outcome of Review
	<p>5. GBME-CO-2025-005 – Received: 10/28/2025 Dr. Berg discussed that this case will be forwarded to the licensee for response, noting that in certain situations, the board can facilitate resolution by working directly with both the complainant and the licensee to address issues without initiating a formal investigation. He explained that in prior instances where communication between a patient and physician was suboptimal but did not fall below the standard of care, resolution was achieved through guided discussions, resulting in the complainant’s satisfaction. Dr. Berg indicated that a similar approach will be taken in this case, while simultaneously adhering to the standard process requiring the physician’s response within 14 days, with the understanding that if resolution is unsuccessful, the matter will proceed through the regular</p>	Dr. Berg		On-Going, Forwarded to Licensee for Response

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	investigative process, and that the decision to attempt this conciliatory approach is at the chair's discretion, so he will proceed in this direction.			
VIII.	<p>New Business</p> <p>A. Complaint(s):</p> <p>1. GBME -CO-2025-006 – Received: 12/02/2025 Dr. Berg noted that a physician has received notification and has been granted a brief extension to respond, and he suggested that B. Hattori forward a reminder to the physician that failure to respond constitutes a violation of the Medical Practices Act, which may result in further disciplinary action, and will be officially reported.</p> <p>B. Applications for Full Licensure:</p> <p>1. Andrew M. Garcia <i>Motion to Approve: Dr. Berg.</i></p> <p>2. Banita B. Sehgal <i>Motion to Approve: Dr. Berg.</i></p> <p>C. Application(s) for Reinstatement of Licensure:</p> <p>1. Divis Khaira Dr. Berg reviewed the reinstatement application for Dr. Khaira, noting a discrepancy between the physician's reported specialty experience and verification from the hospitals where she worked over the past five years, as she claimed to have practiced as a hematologist-oncologist while a hospital indicated she served as a general internist. Dr. Berg indicated that direct primary verification from each hospital will be required before making any recommendation, emphasizing that accurately documenting specialty experience is critical for determining eligibility to practice as a specialist, and that clarification will be sought to determine whether the discrepancy was a minor error or a significant misrepresentation. <i>Motion to Table: Dr. Berg.</i></p> <p>D. Collaborative Practice Agreement(s): Dr. Berg explained that the collaborative practice agreements do not require a board vote, noting that all agreements are in proper form, have been reviewed by the board, and are fully signed.</p> <p>1. Caressa E. Maluweleng</p> <p>2. Fironia Rofail</p>	<p>GBME</p> <p>GBME</p> <p>GBME</p> <p>GBME</p> <p>GBME</p> <p>GBME</p>	<p>Ongoing, Remind Physician to Respond</p> <p>Unanimously Approved</p> <p>Unanimously Approved</p> <p>Tabled</p> <p>Unanimously Approved</p> <p>Unanimously Approved</p>	

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	3. Amanda Walton			Unanimously Approved
	E. 2025 Renewals			
	1. David R. Ferrell	GBME		Unanimously Approved
	2. Duncan E. Thomas			Unanimously Approved
	3. Alejandro R. Prieto			Unanimously Approved
	4. Ria Arlina C. Calata			Unanimously Approved
	5. Gabriel Christopher M. Lapid			Unanimously Approved
	6. Jesse James F. Exaltacion			Unanimously Approved
	7. Dore R. Shafransky			Unanimously Approved
	8. Kevin S. McDermott			Unanimously Approved
	9. Ruben P. Arafiles			Unanimously Approved
	10. Marylou A. Dulay			Unanimously Approved
	11. Weerawat Tananusont			Unanimously Approved
	12. David E. Allen			Unanimously Approved
	13. Jared W. Santana			Unanimously Approved
	14. Jonathon Michael B. Thorp			Unanimously Approved
	15. Daniel E. DeBardeleben			Unanimously Approved
	16. Jeffrey J. Ing			Unanimously Approved
	17. Leon Sam M. Bathini Jr.			Unanimously Approved
	18. Vanessa L. Miller			Unanimously Approved

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	19. Daniel S. Oh			Unanimously Approved
	20. Linh Tieu			Unanimously Approved
	21. Gabriel David			Unanimously Approved
	22. Edward Prodanovic			Unanimously Approved
	23. Leslie Anne Ko Chua			Unanimously Approved
	24. Marie L. Ynson			Unanimously Approved
	25. Edna Ganacias-Acuna			Unanimously Approved
	26. Thomas V. Aubuchon			Unanimously Approved
	27. Caleb R. King			Unanimously Approved
	28. Joel Paulino			Unanimously Approved
	29. Alessandro A. Giambartolomei			Unanimously Approved
	30. Angela T. Lantin			Unanimously Approved
	31. Rome Jutabha			Unanimously Approved
	32. Cynthia Evans			Unanimously Approved
	33. Chawat Tongma			Unanimously Approved
	34. Colton Bush			Unanimously Approved
	35. Kevin Cohen			Unanimously Approved
	36. Jonathan Sidell			Unanimously Approved
	37. Scott Sparks			Unanimously Approved
	38. Ricardo B. Eusebio			Unanimously Approved

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	39. Christian A. Eusebio			Unanimously Approved
	40. Sherleen Osman			Unanimously Approved
	41. Ronald V. Fronda			Unanimously Approved
	42. Taylor Morgan Miles			Unanimously Approved
	43. Steven Hinitt			Unanimously Approved
	44. Ugochukwu E. Akoma			Unanimously Approved
	45. Praveena Madapathi			Unanimously Approved
	46. Axel Rosengart			Unanimously Approved
	47. Davina M. Lujan			Unanimously Approved
	48. Levi Kitchen			Unanimously Approved
	49. Barbara Sewerin			Unanimously Approved
	50. William T. Hancock			Unanimously Approved
	51. Anthony J. Smith			Unanimously Approved
	52. Gregory P. Burton			Unanimously Approved
	53. Timothy Tweito			Unanimously Approved
	54. Charles W. Flores			Unanimously Approved
	55. Luke TJ Moore			Unanimously Approved
	56. Julie Bryson			Unanimously Approved
	57. Edwin Supit			Unanimously Approved
	58. Marian Holland			Unanimously Approved

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	59. Tyler M. Arkless			Unanimously Approved
	60. Scott Sandy			Unanimously Approved
	61. Amy L. Cummings			Unanimously Approved
	62. Justin Hale			Unanimously Approved
	63. Ish K. Gulati			Unanimously Approved
	64. Miechia Esco			Unanimously Approved
	65. May Nguyen			Unanimously Approved
	66. Timothy Li			Unanimously Approved
	67. Doris S. Li			Unanimously Approved
	68. Victor M. Perez			Unanimously Approved
	69. Susie White			Unanimously Approved
	70. Martha Garrison			Unanimously Approved
	71. Angeline H. Huang			Unanimously Approved
	72. Donn LaTour			Unanimously Approved
	73. Esther M. LaTour			Unanimously Approved
	74. Brenda Rea			Unanimously Approved
	75. Anna Leigh Christine O. Ursales			Unanimously Approved
	76. Stephen P. Roesler			Unanimously Approved
	77. Kevin H. Thio			Unanimously Approved
	78. Hugo A. Leon Jr.			Unanimously Approved

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	79. Christopher Paul M. Carbullido			Unanimously Approved
	80. Robert S. Jack			Unanimously Approved
	81. James W. Murphy			Unanimously Approved
	82. Eric Knight			Unanimously Approved
	83. Martha Garrison			Unanimously Approved
	84. Esther Park Hwang			Unanimously Approved
	85. Julia N. Magana			Unanimously Approved
	86. Norma D. Emerson			Unanimously Approved
	87. Ubaldo J. Salazar-Alamillo			Unanimously Approved
	88. Chan S. Hwang			Unanimously Approved
	89. James K. Nozaki			Unanimously Approved
	90. Janie Yoo			Unanimously Approved
IX.	Announcement	Next meeting is tentatively scheduled for Wednesday, March 04, 2026 at 4:00 pm	GBME	Set Date
X.	Adjournment	<i>Motion to Adjourn: Dr. Berg.</i>	GBME	1713 Adjourned

Minutes Drafted by: FLAME TREE Freedom Center, Inc.

Date Submitted:

Submitted by the GBME Secretary:

Date:

Approved by the GBME with or without changes:



Date: 3/24/2026

Certified by or Attested by the Chairperson:



Date: 3/24/2026