

**COUNCIL OF LICENSED MIDWIFERY
TEMPORARY CERTIFICATE APPLICATION
TO PRACTICE IN AREAS OF CRITICAL NEED**

Shall be valid only as long as an area for which it is issued remains an area of critical need but no longer than 2 years and is non-renewable

Temporary Certificate Fee: \$50

Applicant's Information

<hr/> Last Name	<hr/> First	<hr/> MI	<hr/> Home Phone	<hr/> Business Phone		
<hr/> E-Mail Address			<hr/> Street Address		<hr/> Apt.#	
<hr/> Midwifery School						
<hr/> Date Graduated		<hr/> Type of Degree Awarded		<hr/> City	<hr/> State	<hr/> Zip

Have you ever changed your name through marriage or action of a court, or have you ever been known by any other name?.....() Yes () No

If yes, list name(s): _____

Supervisor's Information

<hr/> Last Name	<hr/> First	<hr/> MI	<hr/> Home Phone	<hr/> Business Phone	
<hr/> E-Mail Address			<hr/> Street Address		<hr/> Apt.#
<hr/> Profession: (DO, MD, CNM, LM)					
<hr/> County of Practice		<hr/> City		<hr/> State	<hr/> Zip

APPLICATION HISTORY – GENERAL

Is there a complaint currently pending against you in any jurisdiction or an investigation of your professional conduct or competence in or related to the practice of a profession?.....()Yes ()No

If you answered “yes” you must provide the following documentation with the application when it is filed:

1. *Complete details as to the state(s), license number(s), date(s), and relevant circumstances on attached sheets.*
2. *A copy of any documentation from the state regarding the final actions/outcome of the issue.*

SIGNATURE OF APPLICANT

I have carefully read the questions in the foregoing application and have answered them completely and without reservations of any kind.

Signature

Date Signed

This form must be accompanied by an application for endorsement and documentation of the area of critical need pursuant to Section 467.0125(2)(a), F.S.

The original application and any documents you wish to include with the application, accompanied by the applicable fee should be addressed to the following:

**DEPARTMENT OF HEALTH
Payment Management
P.O. Box 6330
Tallahassee, FL 32314**

Use of the above address will ensure receipt of the application and fee(s).

Any additional documentation (not included with the application), sent either by the applicant or by any other source on your behalf, should be mailed to the following address:

**COUNCIL OF LICENSED MIDWIFERY
4052 Bald Cypress Way, BIN #C-06
Tallahassee, FL 32399-3256**