

**PROFESSIONAL LIABILITY COVERAGE**

NAME: \_\_\_\_\_

LICENSE NUMBER: MW \_\_\_\_\_

Please choose one of the following:

( \_\_\_\_ ) I hereby certify that I have professional liability coverage in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer.

( \_\_\_\_ ) I hereby certify that I am exempt from demonstrating financial responsibility because I fall into one of the categories listed below (circle):

(a.) I practice exclusively as an officer, employee, or agent of the federal government, or of the state of its agencies or subdivisions.

(b.) I have an inactive license, and do not practice in the state of Florida.

(c.) I practice only in conjunction with my teaching duties at an approved midwifery school.

(d.) I do not practice in the state of Florida, but I will submit proof of professional liability coverage at least 15 days prior to practicing midwifery in this state

(e.) I have no malpractice exposure in the state of Florida.

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action or criminal penalties as provided in Chapters 409.908(12)(c), 456.048(2), 467.014, Florida Statutes and Rule 64B24-7.013, Florida Administrative Code.

\_\_\_\_\_  
Signature of licensee (required)

\_\_\_\_\_  
Date of signature

**Division of Medical Quality Assurance  
Council of Licensed Midwifery  
PO Box 6330 • Tallahassee, FL 32314-6330**