Application for Midwifery License by Examination

Department of Health/Council of Licensed Midwifery
P.O. Box 6330
Tallahassee, FL 32314-6330

Website: http://www.floridahealth.gov/licensing-and-regulation/midwifery

Email: mqa.midwifery@flhealth.gov
Phone: (850) 245-4161
Fax: (850) 412-2681

DH-MQA 1051, Revised 4/2022, Rule 64B24-2.001, F.A.C.

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

Florida HEALTH Medical Quality Assurance

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Do Not Write in this Space
For Revenue Receipting Only

More information about the licensing process and requirements is available at www.floridahealth.gov/licensing-and-regulation/midwifery/.

Certified Nurse Midwives (CNM) should not apply with the Council of Licensed Midwifery. CNMs must apply with the Board of Nursing at https://floridasnursing.gov/.

Midwife (3201) by **Examination** (1010) **$705.00**

Total fee of $705.00 includes the following:	
Application Fee (non-refundable)	$200.00
Initial Licensure Fee (refundable)	$500.00
Unlicensed Activity Fee (refundable)	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: ______________________________________ **Date of Birth:** ____________
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

______________________ ______ ______________
Street/P.O. Box Apt. No. City

____________ ______ ____________ ______________
State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

______________________ ______ ______________
Street (Place of Employment) Suite No. City

____________ ______ ____________ ______________
State ZIP Country Work/Cell Telephone

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: Male / Female

Race: Native Hawaiian or Pacific Islander / American Indian or Alaska Native / Two or More Races / Hispanic or Latino / Black or African American / White / Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the council office.

Yes No Email Address: ______________________________

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: ____

First Name: ____

Middle Name: ____

Social Security Number: ____

Social Security Disclosure Information: * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

You may apply for licensure before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.

Name: ____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Include **all** names which may appear on documents submitted in support of your application. Attach additional sheets if necessary.

____

B. Do you hold, or have you ever held a license to practice midwifery or any other health-related license(s)?
Yes No

C. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

For any license(s) listed in question C, you may be required to submit official license verification. Council staff will attempt to verify all licenses listed using available primary-source verification tools (i.e. online verification portals). If primary-source verification is not available, you will be notified in writing that official license verification is required.

4. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

5. EDUCATION AND TRAINING HISTORY

A. **Midwifery Education and Training:** List the midwifery or other training program you attended.

Program Name	Program State or Country	Graduation Date (MM/DD/YYYY)

Applicants who completed their midwifery education and training in Florida must have an official transcript sent directly to the council office from their Florida council approved midwifery program. Unofficial transcripts and copies submitted by applicants are not acceptable.

If you attended a Florida council approved midwifery program:
I authorize the Florida council approved midwifery program listed above to release my transcript.

Applicants educated in another state must have their education and training evaluated by a Florida council approved midwifery program.

Applicants educated in another country must have their education and training evaluated by an education credentialing service.

Uncredentialed education documents and copies of education credentialing documents submitted by applicants will not be accepted.

Credentialing must be completed on Form DH-MQA 5071, "Licensed Midwife Education and Training Evaluation," available online at https://www.floridahealth.gov/licensing-and-regulation/midwifery/resources.

Name: ____

B. **Prelicensure Course:** Applicants educated in another state or country must complete a prelicensure course with a Florida council approved midwifery program.

If you completed your midwifery education in another state or country, list the Florida council approved midwifery program where you completed your prelicensure course.

Approved Midwifery Program Name	Completion Date (MM/DD/YYYY)
I authorize the approved midwifery program listed above to release my prelicensure transcript.	

6. EXAMINATION HISTORY

North American Registry of Midwives (NARM) - Examination Results:

I have not yet taken the required NARM examination.

I have taken the required NARM examination.

All applicants must request that their NARM results be sent directly to the council office. NARM results submitted by applicants will not be accepted.

For additional information about the NARM examination, visit narm.org.

Requests for agency authorization to test made directly by applicants will not be accepted.
If you require authorization to test, contact the Florida council approved midwifery program where you completed your prelicensure course.

7. GENERAL EMERGENCY CARE PLAN

All applicants are required to provide a general emergency care plan pursuant to s. 467.017(1), Florida Statutes.

Submit your general emergency care plan on Form DH-MQA 1077, "General Emergency Care Plan for Licensed Midwives." The form is available online at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources.**The form required in this section may be submitted with your application.**

After submission of this application, the required form may be submitted by:

- uploading the form using the MQA Online Services Portal (www.flhealthsource.gov),
- emailing the form to MQA.Midwifery@flhealth.gov, or
- mailing the form to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

Name: ____

This information is exempt from public records disclosure.

8. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the council office:

A written self-explanation which identifies the medical condition(s) or occurrence(s) and current status.

A letter from a Licensed Health Care Practitioner who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on your ability to practice the profession with reasonable skill and safety. The letter must specify that you are safe to practice the profession without restrictions, or indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- uploading the documents using the MQA Online Services Portal (www.flhealthsource.gov),
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Name: ______________________________

9. DISCIPLINE HISTORY

A. Have you ever had any professional license or license to practice revoked, suspended, placed on probation, or received a disciplinary action taken in any state, territory, or jurisdiction? Yes No

B. Have you ever had any application for a license to practice a profession, including midwifery, denied by any state board/council or the licensing authority of any state, territory, or jurisdiction? Yes No

C. Are you currently under investigation or is any disciplinary action pending against you in any state, territory, or jurisdiction that would constitute a violation of s. 467.203, Florida Statutes? Yes No

D. Have you ever been notified to appear before any licensing agency for a hearing on a compliant of any nature, including, but not limited to, a charge of violation of the midwifery and/or medical practice act(s), for unprofessional or unethical conduct? Yes No

If you responded "Yes" to any of the questions above, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" to question A, B, C, or D, you must provide the following:

A written self-explanation, which describes in detail the circumstances surrounding each disciplinary action, denial, investigation, or hearing.

A copy of the **Administrative Complaint** and **Notice of Intent to Deny or Final Order**.

Any other relevant filings entered by the licensing agency related to the action taken.

E. Have you ever had any judgements entered against you related to the practice of midwifery or any other health care profession? Yes No

F. Have you ever been sued for malpractice? Yes No

If you responded "Yes" to question E or F, you must provide the following:

A written self-explanation which describes in detail your involvement in each case.

A copy of the **Complaint** and **Disposition** for each case.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

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- emailing the documents to MQA.Midwifery@flhealth.gov, or
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Tallahassee, FL 32399-3255

Name: ____

10. CRIMINAL HISTORY

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

B. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? Yes No

If you responded "Yes" to any question in this section, complete the following:

Offense	Jurisdiction/State	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" to any question in this section, you must provide the following:

A written self-explanation which describes in detail the circumstances surrounding each offense and includes the date of the offense, where the offense occurred (city and state), the charge(s), and the final disposition(s).

Arrest Records and Final Dispositions for all offenses. The Clerk of Court in the jurisdiction where the offense took place will provide you with these documents. *If records are unavailable*, documentation of the unavailability of records must come from the Clerk of Court in the jurisdiction where the offense took place, in the form of a letter which states that the records are unavailable.

Completion of Sentencing Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the sentence was completed.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

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- emailing the documents to MQA.Midwifery@flhealth.gov, or
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Name: ____

11. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

If you responded "No" to the question above, skip to question 2.

a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? Yes No

c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)? Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

If you responded "No" to the question above, skip to question 3.

a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida Statutes? Yes No

If you responded "No" to the question above, skip to question 4.

a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No

Name: ____

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded "No" to the question above, skip to question 5.

a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

b. Did termination occur at least 20 years before the date of this application? Yes No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation for each "Yes" response which describes in detail the circumstances surrounding the termination or conviction and includes the county and state of each termination or conviction and the date of each termination or conviction.

Copies of supporting documentation includes court dispositions or agency orders, if applicable.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

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- emailing the documents to MQA.Midwifery@flhealth.gov, or
- mailing the documents to:

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Tallahassee, FL 32399-3255

Name: ____

12. FINANCIAL RESPONSIBILITY

Midwives are required to carry professional liability insurance coverage in an amount not less than $100,000.00 per claim with a minimum annual aggregate of not less than $300,000.00 through an authorized insurer as defined under s. 624.09, Florida Statutes, a surplus lines insurer as defined under s. 626.914., Florida Statutes, a risk retention group as defined under s. 627.942, Florida Statutes, the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or a plan of self-insurance as provided in s. 627.357, Florida Statutes, unless exempt from financial responsibility coverage for one of the reasons below.

Council staff cannot advise as to your financial responsibility or malpractice insurance coverage. If you have questions regarding your financial responsibility, insurance coverage, or requirements for exemption, consult your legal counsel, insurance company, or financial institution.

Choose only one option that describes your professional liability insurance coverage status or exemption from financial responsibility.

I have obtained and will maintain professional liability insurance coverage in an amount not less than $100,000.00 per claim with a minimum annual aggregate of not less than $300,000.00 from a provider as described herein.

I am exempt from financial responsibility coverage because I practice exclusively as an officer, employee, or agent of the federal government, or of the state of Florida or its agencies or subdivisions.

I am exempt from financial responsibility coverage because I will be practicing exclusively in conjunction with my teaching duties with an approved midwifery program.

I am exempt from financial responsibility coverage because I will not be practicing in the state of Florida upon issuance of my midwifery license and will submit proof of professional liability coverage at least 15 days prior to beginning practice in the state of Florida.

I am exempt from financial responsibility coverage because I have no malpractice exposure in the state of Florida.

Providing false information in response to this question may result in denial of licensure or disciplinary action against your license once issued, and/or criminal penalties as provided in s. 456.067, 456.072, 467.201(5), 456.203(1)(a), 775.082, 775.083, and 775.084, Florida Statutes.

13. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

Florida law requires me to immediately inform the council of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the Department of Health.

Applicant Signature ____ Date ________________

You may print this application and sign it or sign digitally. MM/DD/YYYY