

**STATE OF FLORIDA
DEPARTMENT OF HEALTH**

Council of Licensed Midwifery



**APPLICATION FOR LICENSURE
WITH INSTRUCTIONS**

**4052 Bald Cypress Way, Bin # C06
Tallahassee, FL 32399-3255
(850) 488-0595**

Website: www.flhealth.gov

**DEPARTMENT OF HEALTH
COUNCIL OF LICENSED MIDWIFERY
APPLICATION CHECKLIST FOR LICENSURE**

This checklist is a guide to assist you in submitting the required documentation to determine licensure eligibility. Please make a copy of all documentation for your records, prior to mailing the originals to the department. Your application will be reviewed within 30 days from receipt of your application and fees you will be notified via mail of your application status.

IMPORTANT NOTICE!

Effective July 1, 2009, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and shall refuse to admit a candidate for examination if the applicant has been:

- Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;
- Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
- Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of the application.

Basic Documentation:

- Complete application, please print clearly or type.
- FEE:** Cashier's check or money order made payable to the Department of Health
 - Licensure by **Examination** (Total **\$705.00**)
 - Application Fee \$200.00 (non-refundable)
 - Licensure Fee \$500.00
 - Unlicensed Activity Fee \$5.00
 - License by **Endorsement** (Total **\$955.00**)
 - Application Fee \$200.00 (non-refundable)
 - Endorsement Fee \$250.00
 - Licensure Fee \$500.00
 - Unlicensed Activity Fee \$5.00
- Complete the "Confidential and Exempt from Public Records Disclosure" form.
- Complete the "Proof of Liability Coverage" form.
- Complete the "Emergency Back-Up Plan for Licensed Midwifery Patients" form.
- High School Diploma or Equivalent
- Proof of 2 hours of prevention of medical errors
- Proof of 1 hour of HIV (Human Immunodeficiency Virus)
- Documentation/written explanation/court documents for "Yes" answers on #17-31 of application

Based on one of the below licensure methods, additional documents are required.

Examination – Based on Florida Approved Midwifery Training Program:

- ❑ Official transcript from an (Florida) approved midwifery training program which includes:
 - all courses successfully completed
 - date of graduation
 - degree, certificate or diploma granted
- ❑ Official documentation mailed directly from North American Registry of Midwives' (NARM) certifying a passing exam score.

Endorsement – Based on another State License:

- ❑ Official verification of certificate or license to practice midwifery in another state, submitted to our office **directly** from the issuing state. At least one license or certificate must be current, valid and unrestricted
- ❑ Copy of the other state's laws and rules under which the certificate or license was issued
- ❑ Official certificate or diploma from a midwifery program approved by the certifying body of the state in which it was located or an authenticated copy of that certificate or diploma
- ❑ Official transcript from the midwifery program which documents classroom instructions and clinical training
- ❑ Evidence of a passing score on the licensure examination (North American Registry of Midwives **NARM**)
- ❑ Evidence of successful completion of an approved 4-month pre-licensure midwifery training program (please see additional requirements)

Endorsement – Based on Foreign Trained:

- ❑ Valid certificate or diploma from either a foreign institution of medicine or a foreign school of midwifery
- ❑ Certified translation of the certificate or diploma earned from a foreign institution of medicine or foreign school of midwifery
- ❑ Document which renders the foreign trained applicant eligible to practice medicine or midwifery in the country in which that document was issued
- ❑ Certified translation of the certificate, diploma or license which renders the foreign trained applicant eligible to practice medicine or midwifery in the country from which the diploma or certificate was awarded
- ❑ Clarification of the existence of any deviation as to how the applicant's name appears on the face of documents in support of this application
- ❑ Evidence of a passing score on the licensure examination
- ❑ Evidence of successful completion of an approved 4-month pre-licensure midwifery training program (please see additional requirements)

Approved 4-Month Pre-Licensure Training Program:

Applicants who received education and training outside of Florida are required to take a 4-Month Pre-Licensure Course by an approved Florida program. To establish educational eligibility for acceptance into the required 4-month pre-licensure course may do so through one of the following:

- Have your education reviewed for substantial equivalency through the use of an approved Education Credentialing Agency. The following Agencies are currently approved:
 - International Credentialing Associates, Inc.
 - Josef Silny and Associates, Inc.
- Receive determination of substantial equivalency through the Department of Health, Council of Licensed Midwifery by submitting the following:
 - Completed Application for 4-Month Pre-Licensure Course
 - \$100.00 Application Fee (Non-Refundable)

All candidates wishing to take the examination must apply directly to the North American Registry of Midwives (NARM). Please contact NARM's testing center at 1-888-353-7089 for examination application and information.

All fees must accompany the application for processing. The application is valid for only one year. If the application is not completed within one year, a new application, documentation and fees will be required again. Should an applicant be deemed ineligible for licensure, the application fee is non-refundable.

WHERE TO SEND APPLICATION AND DOCUMENTATION

Where to send the application: The original application plus fees (cashiers check or money order) and supporting documentation should be sent **in the same envelope** to:

Department of Health
Council of Licensed Midwifery
Post Office Box 6330
Tallahassee, Florida 32314-6330

The use of this address will ensure the receipt of the application by the office where the fees will be processed. The application and supporting documentation will then be logged in and forwarded to the Council office.

Where to send supporting documentation not sent with the application: Any additional documentation, sent either by yourself or by another individual for you, which was not submitted with the original application, should be mailed to the following address:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C06
Tallahassee, FL 32399-3256

INSTRUCTIONS FOR COMPLETING THE APPLICATION

The following instructions are numbered so that they correspond with the numbered sections of the application. Each instruction gives specific information regarding the corresponding section of the application. It is recommended that you maintain a copy of the instructions and application should you need to refer to them during the application process. A response must be provided in each section. If a question does not pertain to you indicate "N/A" in that section. All questions with "YES/NO" answers must have either "YES" or "NO" marked. No other response is acceptable.

ADDITIONAL SPACE NOTE: If any of the sections in the application do not contain sufficient space for the requested information, use an additional page or the reverse side of the application page on which the question is located. Always number the additional information with the corresponding number of the question on the application.

1 -Names: List your full last name. Type a hyphenated last name in the same space. A hyphenated last name will be recognized by the first letter of the first name (i.e.) Diaz-Balart will be filed under Diaz. List your full first name, no nicknames or shortened versions. List your full middle name, if you have one. If you have two, type them in the same space. If you do not have a middle name please indicate N/A.

2-6 - List your Date of Birth, Place of Birth, Home/Work Telephone Number and E-Mail Address.

7 - Mailing address: This should be the address where you will receive correspondence we send regarding your file.

8 – Physical/Primary Practice Address: This should be the address where you are currently practicing or where you can be physically located. **NOTE:** Do not list P.O. Boxes. In the event that either of your addresses changes during the application process, submit the new address(s) immediately.

9 -Name Changes: If you have ever changed your name by marriage or other court action, you must submit legal documentation of the change with your application (if you have been married more than once all marriage and divorce documents must be submitted.) List your maiden name in the space provided. **NOTE:** If you use any names other than your legal name, but have not legally changed your name, list such name(s) in the space provided under "other" in this section. If you are married but use a maiden name professionally, please indicate this.

10 - Response to this section is voluntary.

11 - List your U.S. Citizenship. If No, you must provide your alien number.

12 - Provide the name, location, dates attended and degree earned of where you attended high school or where you received your general equivalency diploma.

13 - Provide the name, location, dates attended and degree earned of the midwifery school(s) you attended. Submit a notarized copy of the diploma. If the degree is in any language other than English it must be accompanied by a certified translation of that degree.

14 - Provide the name, location, dates attended and degree earned for all post-secondary, health care, and/or medical education training. Provide a copy of the diploma. If the degree is in any language other than English it must be accompanied by a certified translation of that degree. List the programs chronologically starting with the first program attended and ending with the last (or current) program attended.

15 - Staff Privileges. Provide the name, location, type of privilege, chief of staff and dates of service chronologically starting with your first position and ending with the last (or current) position.

16 - If you HAVE EVER BEEN issued a license, full or temporary, to practice as a midwife, health care provider and/or medical doctor in the United States, list the license(s) in this section. NOTE: You are responsible for contacting all of the states listed to request verification. The state you are/were licensed in must send the verification form directly to the Council of Licensed Midwifery at the address on the form. Some states charge a verification fee. See the attached Licensure Verification form.

Column One: List the state which issued the license, standard two letter postal abbreviations are acceptable.

Column Two: List the month and year the license was issued. Confirm this date with that state Board.

Column Three: Indicate how the license was issued: by endorsement (END), state exam (EXAM), reciprocity (RECIP/LIST STATE), as applicable. If issued by some other means, type (OTHER) and explain in full on additional space.

Column Four: List current status of license(s) and the respective number(s). Denote as either active(ACT) or inactive (INACT). If in another status, list (OTHER) and explain on additional space.

17 - 19 - Answer "YES" or "NO". Provide copies of ALL documents if your answer is "YES". Note: The 4 month pre-licensure course must be verified by at least one of the following: An official transcript which includes course titles, grades received and dates of the program, an original letter on letterhead stationery from the director of the program which states the applicant successfully completed the pre-licensure course, the grades earned and the dates of attendance, or a certificate stating the successful completion of the pre-licensure course and the dates of attendance, signed by the director of the program.

20 – If you answer YES, NARM must provide documentation directly to the Council office stating you have passed.

21 - 27 - If your answer is "YES", submit a statement for that answer and provide documentation as requested on the application form.

28 - If yes, please provide an explanation on a separate sheet. You must also submit CERTIFIED copies of all pertinent court/arrest documents, including arrest report, official charges, restoration of civil rights (if applicable) and current disposition.

29 - If yes, provide an explanation on a separate sheet. You must also direct the Medicaid program to submit all pertinent documentation directly to the Board office.

30 - If yes, provide an explanation on a separate sheet. You must also direct the state Medicaid program or the federal Medicare program to submit all pertinent documentation directly to the Board office.

31 - If you have worked in any health care profession within the past 3 years fill in the place of employment, complete mailing address, and beginning and ending dates of employment. Month and year are acceptable. Mail the Employment Verification Form (if employment was within the United States) to your employers and allow appropriate time for Department receipt.

32 -This section of the application must be completed. The applicant's name must be printed in the first blank and signed in the second blank. This section will be copied and used as a release of information when needed; therefore, the signature must be a full signature to be acceptable.

You must notify us immediately of any occurrences which would change or affect in any way, an answer or response you have given in the application. Failure to do so could result in the denial of your application or revocation of your license.

11. HIGH SCHOOL EDUCATION OR EQUIVALENCY				
Name and Location of School		Dates Attended	Degree	
12. MIDWIFERY EDUCATION				
Name and Location of School		Dates Attended	Degree	
13. POST-SECONDARY, HEALTHCARE OR MEDICAL EDUCATION (does not apply indicate N/A)				
Name of Institution	Full Mailing Address	Dates Attended	Degree	
14. LIST HOSPITALS WHERE YOU HAVE HELD STAFF PRIVILEGES (does not apply indicate N/A)				
Name of Institution	Mailing Address	Type of Privileges	Chief of Staff	Dates of Service
15. STATE LICENSURE: List all states that you are or have ever been licensed in as a midwife, health care provider, and/or medical doctor. Give area of licensure, license number, date of issuance and method such as examination, endorsement, grand-fathered, reciprocity, etc. Does not apply indicate N/A.				
State/Country	Date	Type of License	License Number	Method

QUESTIONS 16 through 19 MUST BE ANSWERED YES OR NO		YES	NO
17.	a. Do you hold a valid certificate or diploma from a foreign institution of medicine?		
	b. In addition, do you hold a valid document from a foreign country authorizing you to practice medicine in that country? If yes, submit official documentation.		
17.	Do you hold a valid certificate from a midwifery program offered in another state or country bearing the seal of the institution, or otherwise authenticated, which renders you eligible to practice midwifery in the country or state in which it was issued? If yes, submit official documentation.		
18.	Have you successfully completed an approved 4 month pre-licensure course in Florida? If yes, submit official documentation of a passing score. See instructions.		
19.	Have you successfully completed the licensed midwifery examination? If yes, request official documentation be sent directly from NARM of a passing score.		
Questions 20 - 26 must be substantiated by either official documents sent directly to the Council office from the respective state licensing board or official copies of court records. A YES answer to any of these questions is <u>NOT</u> an automatic cause for denial of licensure.			
20.	Have you ever been notified to appear before any licensing agency for a hearing on a complaint 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?		
21.	Have you ever had midwifery or other health care license acted on, revoked, suspended or had any disciplinary action taken in any state, territory or country?		
22.	Have you ever had midwifery, medical or other health care application for licensure denied by any state board or other governmental agency of any state, territory or country?		
23.	Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.		
	If the answer to question 24 above is “yes” then answer the following questions:		
	a. Does the violation involve allegations of driving under the influence of or driving while impaired by drugs or alcohol?		
	b. Does the violation involve allegations of sexual misconduct, sexual batter, lewd or lascivious conduct, indecent exposure or any crime involving sexual activity?		
24.	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?		
25.	Have you ever had any judgments entered against you related to the practice of midwifery or any other health care field?		
26.	Have you ever been sued for malpractice?		
Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.		Yes	No
27.1	(a) Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded “no”, skip to # 7.2.)		
	(b) If “yes” to 7.1.a., have you successfully completed a drug court program for a felony offense that resulted in the plea being withdrawn or charges dismissed? (If “yes”, please provide supporting documentation)		

	(c) If "yes" to 7.1.a., for felonies of the first or second degree, has it been more than 15 years before the date of application?	
	(d) If "yes" to 7.1.a., for felonies of the third degree, has it been more than 10 years before the date of application, except for felonies of the third degree under Section 893.13(6), Florida Statutes?	
	(e) If "yes" to 7.1.a., for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years before the date of application?	
27.2	(a) Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	
	(b.) If "yes" to 7.2.a., 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?	
27.3	(a.) Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 7.3.b.)	
	(b.) If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	
27.4	(a.) Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program? (If "No", do not answer 7.4.b. or 7.4.c.)	
	(b.) Have you been in good standing with a state Medicaid program for the most recent five years?	
	(c.) Did the termination occur at least 20 years before the date of this application?	
27.5	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	
27.6	On or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by the Board of Acupuncture or Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	

31. LIST ALL EMPLOYMENT IN ANY HEALTH CARE PROFESSION FOR THE PAST THREE YEARS (does not apply indicate N/A)

Place of Employment	Full Mailing Address	Dates of Employment

32. SIGNATURE OF APPLICANT

I, (Print your name) _____, state that I am the person referred to in the foregoing application and supporting documentation, that said application and any supporting documentation are true and accurate and that the attached photograph is a true likeness of myself.

I hereby authorize all hospitals, institutions, organizations, references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department of Health any information, files or records requested by the Department in connection with the processing of this application. I further authorize the Department of Health to release to the organizations, individuals and/or groups listed above any information which is material to my application.

I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education requirements.

I have carefully read the questions in the foregoing application and have answered them completely and without reservations of any kind. I declare that my answers and all statements made by me herein are true and correct. Should I knowingly make a false statement in writing with the intent to mislead a public servant in the performance of their official duty, I shall be guilty of a misdemeanor in the second degree punishable as provided in Chapter 775.082, 775.083, or 775.084, Florida Statutes.

Signature of Applicant

Date Signed



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 have attached copy of my insurance certificate)

() 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 Sections 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

Council of Licensed Midwifery
Tallahassee, FL 32314-6330



Pursuant to Section 467.017, Florida Statutes, F. A. C., a midwife is required to file with the department upon initial application and each biennial renewal, an emergency care plan that shall be implemented as needed in the practice setting.

EMERGENCY BACK UP PLAN FOR LICENSED MIDWIFERY PATIENTS

Department of Health -Council of Licensed Midwifery – PO Box 6330, Tallahassee, FL 32314-6330

Homebirth Birth Center Hospital

(Midwives practicing in facilities with a standard emergency care plan, please attach a copy of your facility plan or complete the following for your facility.)

Midwife's Name: _____

Home Address: _____

Home Phone: () _____ - _____ Office Phone: () _____ - _____ Pager: () _____ - _____

Business/Facility Name: _____ Phone () _____ - _____

Address: _____

EMERGENCY TRANSFER HOSPITAL:

(List first and second option in your practice area -please check box if facility has NICU/Perinatal services)

1. Hospital: _____ E. R. #: () _____ - _____ L&D #: _____ - _____

Address: _____ NICU Perinatal Unit

2. Hospital: _____ E. R. #: () _____ - _____ L&D #: _____ - _____

Address: _____ NICU Perinatal Unit

PLAN FOR CONSULTATION WITH OTHER HEALTH CARE PROVIDERS AND EMERGENCY TRANSFER:

Name of Emergency Medical Services (EMS) 911 Transport Entity:

City _____ County _____

BACKUP PHYSICIAN ARRANGEMENT: (if any)

Physician Name: _____ Phone: () _____ - _____

Address: _____

AFFIRMATION:

In the event complications arise during my patient's pregnancy, labor, delivery or postpartum, I will implement the Emergency Care Plan individualized for each patient accepted into my care, according to the guidelines contained herein. I will consult, refer or transfer to the appropriate health care facility as medically necessary, and provide emergency management. In order to facilitate the safe transfer of services and to provide continued supportive care to the extent that I am able, I will accompany my patient during transfer to provide relevant patient data and documentation and give report to the accepting provider.

Midwife's Signature: _____ Date: _____