



# FLORIDA | Council of Licensed Midwifery

**AGENDA OUTLINE**  
**October 14, 2015**  
**9:00 a.m.**

**Omni Orlando Resort at Championsgate**  
**1500 Masters Boulevard**  
**Championsgate, Florida 33896**

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The meeting will be called to order at 9:00 am or soon thereafter.

**Call to Order:**           **Melissa Conord-Morrow, LM, Chair**  
**Roll Call:**               **Executive Director**

**Review and Approval of Minutes from Previous Meeting:**

1. July 13, 2015 General Business Meeting Minutes

**Rule Discussion**

2. 64B24-7           Midwifery Practice  
Comments from Dana Barnes, MD – Family Practice Physician  
WSMA Indications for Discussion, Consultation and Transfer  
Midwives Association of Florida Comments  
HealthNet Prenatal Perinatal Guidelines
3. 64B24-1.004 Terms, Meetings, ~~Quorum~~, and Absences
4. 64B24-2.001    Licensure to Practice Midwifery
5. 64B24-2.0011   Forms
6. 64B24-2.002    Examination
7. 64B24-2.003    Licensure by Examination
8. 64B24-2.004    Licensure by Endorsement
9. 64B24-3.002    Application Fees
10. 64B24-3.003   Examination Fee
11. 64B24-3.004   Endorsement Fee

12. 64B24-3.005 Initial License Fee
13. 64B24-3.006 Temporary Certificate Fee
14. 64B24-3.007 Active Biennial Renewal Fee
15. 64B24-3.008 Delinquent Fee
16. 64B24-3.009 Reactivation Fee
17. 64B24-3.011 Duplicate License Fee
18. 64B24-3.013 Continuing Education Provider Application Fee
19. 64B24-3.014 Unlicensed Activity Fee
20. 64B24-3.015 Change of Status Fee
21. 64B24-3.016 Inactive Renewal Fee
22. 64B24-3.017 Retired Status Fee

**2015 Annual Report of Midwifery Practice Form (final draft)**

**Old Business**

**New Business**

**Adjourn**

**Next Meeting: February 8, 2016**



# FLORIDA | Council of Licensed Midwifery

**Draft Meeting Minutes**

July 13, 2015 at 9:00 am

Telephone Conference Call  
Call in Number: 888-670-3525  
Participant Passcode: 360897569

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## **Call to Order:**

The meeting was called to order by Ms. Conord-Morrow, Chair, at 9:00 am. Those present for all or part of the meeting included the following:

### **MEMBERS PRESENT:**

Melissa Conord-Morrow, RN, LM, Chair  
Dana Barnes, MD  
Kathy Bradley, Consumer Member  
Robyn Mattox, LM  
Tania Mondesir, RN, LM  
David Stewart, MD  
Charlie Young, LM

### **MEMBERS ABSENT:**

Stephanie Wombles, CNM  
Robert Pearson-Martinez, MD

### **STAFF PRESENT:**

Christy Robinson, Executive Director  
Daisy King, Program Operations Administrator  
Linda McMullan, Assistant General Counsel

### **COURT REPORTER:**

For the Record Reporting  
850-222-5491

Please note that the meeting minutes reflect the actual order that agenda items were discussed during the meeting and may differ from the agenda outline.

**Due to time constraints all agenda items were not discussed by the Council.**

## **General Business:**

### **Tab 3 – 2016 Proposed Meeting Dates**

It was the consensus of the Council that the following dates were acceptable for 2016: February 8, 2016, June 6, 2016, August 16, 2016 and October 3, 21016.

## **Rules Review and Discussion**

### **Tab 10 - 64B24-7 Midwifery Practice**

#### **64B24-7.014 – Records and Reports**

The Council discussed the proposed draft form provided by Ms. Mattox. Several edits were suggested, including:

- Addition of the number of water births
- Addition of the number of mothers requiring sutures
- Differentiation between planned and unplanned antepartum transfers
- Addition of the number of initial visits not accepted into care
- Change the number of planned breech births to unplanned breech births

Ms. Robinson and Ms. McMullen expressed the importance of getting the draft form into the rule as soon as possible so that the Department could begin collecting data for the January 2016-June 2016 reporting period.

#### **Reference Material and Correspondence:**

#### **Tab 14 – Comments Received from the Midwives Association of Florida (MAF)**

The Department received several comments and suggested revisions from MAF as a result of the April 27, 2015 rules workshop. The Council discussed all of the comments except those regarding midwifery practice.

64B24-2.004 – it was the consensus to not make the suggested changes because the requirement is listed in statute.

64B24-4.010 – it was the consensus to add the post-partum and newborn exams to the rule language but not add the rest of the suggested changes.

64B24-4.007(5) – it was the consensus to add language requiring “at least” five vaginal repairs to the rule.

64B24-4.007(2) – it was the consensus to research this issue further and bring the discussion back to the next meeting. There was concern about allowing students to obtain their supervised births outside of Florida. There was also discussion that this practice can be beneficial, when done appropriately, and should not be limited.

64B24-3.005 – it was the consensus to not make the suggested changes to reduce the fee because the Council was already in a chronic deficit.

64B24-7.001, 7.004, 7.006 and 7.007 - these items were not discussed due to time constraints. The Council was asked to provide their comments via email regarding these suggested changes.

The Council asked that the October 2015 meeting be held in person because of the nature of the rules they needed to discuss. Ms. Robinson indicated she would coordinate a date with the Council via email.

The meeting adjourned at 11:50 am.

**CHAPTER 64B24-7  
MIDWIFERY PRACTICE**

- 64B24-7.001 Definitions
- 64B24-7.003 Acceptance of Patients (Repealed)
- 64B24-7.004 Risk Assessment
- 64B24-7.005 Informed Consent
- 64B24-7.006 Preparation for Home Delivery
- 64B24-7.007 Responsibilities of Midwives During the Antepartum Period
- 64B24-7.008 Responsibilities of Midwives During Intrapartum
- 64B24-7.009 Responsibilities of the Midwife During Postpartum
- 64B24-7.010 Collaborative Management
- 64B24-7.011 Administration of Medicinal Drugs
- 64B24-7.013 Requirement for Insurance
- 64B24-7.014 Patient Records
- 64B24-7.015 Advertising
- 64B24-7.016 Sexual Misconduct (Repealed)
- 64B24-7.018 Address of Record

**64B24-7.001 Definitions.**

As used in this rule chapter, the term:

- (1) "Consultation" means communication between a licensed midwife and a health care provider for the purpose of assessing a potential or actual problem relevant to the patient.
- (2) "Referral" means a request made by a licensed midwife to a physician, or ARNP for an assessment of a patient to determine management for or a resolution to a problem relating to the health of the patient.
- (3) "Transfer" means a formal dissolution of care to the patient by a licensed midwife which results in such care being assumed by another health care provider.

*Specific Authority 467.005 FS. Law Implemented 467.005 FS. History--New 7-14-94, Formerly 61E8-7.001, 59DD-7.001, Amended 9-11-02.*

**64B24-7.003 Acceptance of Patients.**

*Specific Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History--New 7-14-94, Formerly 61E8-7.003, 59DD-7.003, Repealed 2-6-08.*

**64B24-7.004 Risk Assessment.**

(1) For each patient, the licensed midwife shall assess risk status criteria for acceptance and continuation of care. The general health status and risk assessment shall be determined by the licensed midwife by obtaining a detailed medical history, performing a physical examination, and taking into account family circumstances along with social and psychological factors. The licensed midwife shall risk screen potential patients using the criteria in this section. If the risk factor score reaches 3 points the midwife shall consult with a physician who has obstetrical hospital privileges and if there is a joint determination that the patient can be expected to have a normal pregnancy, labor and delivery the midwife may provide services to the patient. When a client has a risk score of 3 or higher and has previously had a physician consultation for the identical risk factors in a prior pregnancy with no current changes in health or risk factors another consultation is not required.

(2) The licensed midwife shall continue to evaluate a patient during the antepartum, intrapartum and postpartum. If the cumulative risk score reaches three points or higher and the patient is not expected to have a normal pregnancy, labor and delivery, the midwife shall transfer such patient out of his or her care. The midwife may provide collaborative care to the patient pursuant to Rule 64B24-7.010, F.A.C.

(3) The risk factors shall be scored as follows:

Score

(a) Socio-Demographic Factors.

- 1. Chronological age under 16, or older than 40.

2. Residence of anticipated birth more than 30 minutes from emergency care.	3
(b) Documented Problems in Maternal Medical History.	
1. Cardiovascular System	
a. Chronic hypertension.	3
b. Heart disease.	3
c. Heart disease assessed by a cardiologist which places the mother or fetus at no risk.	1
d. Pulmonary embolus.	3
e. Congenital heart defects.	3
(i) Congenital heart defects assessed by a cardiologist which places the mother or fetus at no risk.	1
2. Urinary System	
a. Renal disease.	3
b. History of pyelonephritis.	1
3. Psycho-Neurological	
a. History of psychotic episode adjudged by psychiatric evaluation and which required use of drugs related to its management, but not currently on medication.	1
b. Current mental health problems requiring drug therapy.	3
c. Epilepsy or seizures in the last two years.	3
d. Required use of anticonvulsant drugs.	3
e. During the current pregnancy, drug or alcohol addiction, use of addicting drugs.	3
f. Severe undiagnosed headache.	3
4. Endocrine System	
a. Diabetes mellitus.	3
b. History of gestational diabetes.	1
c. Current thyroid disease.	
(i) Euthyroid.	1
(ii) Non-Euthyroid	3
5. Respiratory System	
a. Chronic bronchitis.	1
(i) Current or chronic or with medication.	3
(ii) Without medication or current problems.	1
b. Smoking.	
(i) 10 or less cigarettes per day.	1
(ii) More than 10 cigarettes per day.	3
6. Other Systems	
a. Bleeding disorder or hemolytic disease.	3
b. Cancer of the breast in the past five years.	3
7. Documented Problems in Obstetrical History	
a. Expected Date of Delivery (EDD) less than 12 months from date of previous delivery.	1
b. Previous Rh sensitization.	3
c. 5 or more term pregnancies.	3
d. Previous abortions.	
(i) 3 or more consecutive spontaneous abortions.	3
(ii) Two consecutive spontaneous abortions or more than three spontaneous abortions.	1
(iii) 1 septic abortion.	3
e. Uterus.	
(i) Incompetent cervix, with related medical treatment.	3
(ii) Prior uterine surgery	3
(iii) Prior uterine surgery followed by an uncomplicated vaginal birth.	2

- f. Previous placenta abruptio. 3
- g. Previous placenta previa. 1
- h. Severe pregnancy induced hypertension during last pregnancy. 2
- i. Postpartum hemorrhage apparently unrelated to management. 3
- 8. Physical Findings of Previous Births
  - a. Stillbirth occurring at more than 20 weeks gestation or neonatal loss (other than cord accident). 3
  - b. Birthweight.
    - (i) Less than 2500 grams or two or more previous premature labors without a subsequent low risk pregnancy and full term appropriate for gestational age (AGA) infant. 3
    - (ii) Less than 2500 grams or two or more previous premature labors with one or more full term AGA infant(s) subsequently delivered, after a low risk pregnancy. 1
    - (iii) More than 4000 grams. 1
  - c. Major congenital malformations, genetic, or metabolic disorder. 3
- 9. Maternal Physical Findings
  - a. Gestation.
    - (i) Of more than 22 weeks in the patient’s first pregnancy (nullipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care. 3
    - (ii) Of more than 28 weeks if the patient has had at least one previous viable birth (multipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care. 3
  - b. Prepregnant weight is not within the range of the following weights by height: 2

Height in Inches Without Shoes	Prepregnant Minimum Weight in Pounds	Prepregnant Maximum Weight in Pounds
56	83	143
57	85	146
58	86	150
59	89	153
60	92	157
61	95	161
62	97	166
63	100	170
64	103	175
65	106	180
66	110	185
67	113	190
68	117	196
69	121	202
70	124	208
71	128	212
72	131	217
73	135	222

- c. Evidence of clinically diagnosed pathological uterine myoma or malformations, abdominal or adnexal masses. 3



d. Polyhydramnios or oligohydramnios.	
(i) Prior pregnancy.	2
(ii) Current pregnancy.	3
e. Cardiac diastolic murmur, systolic murmur grade III or above, or cardiac enlargement.	3
10. Current Laboratory Findings	
a. Hematocrit/Hemoglobin.	
(i) Less than 31% or 10.3 gm/100 ml.	1
(ii) Less than 28% or 9.3 gm/100 ml.	3
b. Sick cell anemia.	3
c. Pap smear suggestive of dysplasia.	3
d. Evidence of active tuberculosis.	3
e. Positive serologic test for syphilis confirmed active.	3
f. HIV positive.	3

*Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History--New 7-14-94, Formerly 61E8-7.004, 59DD-7.004, Amended 9-11-02, 2-2-06, 4-1-09.*

**64B24-7.005 Informed Consent.**

(1) A licensed midwife shall obtain a patient's consent for the provision of midwifery services. Such consent shall be recorded on the Informed Consent for Licensed Midwifery Services, Form DH-MQA 1047, revised 3/01, which is hereby adopted and incorporated by reference, and can be obtained from the Council of Licensed Midwifery, 4052 Bald Cypress Way, BIN #C06, Tallahassee, Florida 32399-3256.

(2) To complete the consent form, the licensed midwife shall inform the patient of:

- (a) The licensee's qualifications to perform the services rendered.
- (b) The nature and risks of the procedures to be used.
- (c) The advantages of the procedures to be used.
- (d) Professional liability insurance status.

(3) A signed copy of the consent form shall be placed in the patient's record.

*Specific Authority 467.005 FS. Law Implemented 467.014, 467.015(1)(a), 467.016 FS. History--New 7-14-94, Formerly 61E8-7.005, 59DD-7.005, Amended 5-31-01, 9-11-02.*

**64B24-7.006 Preparation for Home Delivery.**

(1) For home births, the licensed midwife shall:

(a) Encourage each patient to have medical care available by a health care practitioner experienced in obstetrics throughout the prenatal, intrapartal and postpartal periods, and

(b) Make a home visit by 36 weeks of pregnancy. The licensed midwife shall ensure that the setting in which the infant is to be delivered is safe, clean and conducive to the establishment and maintenance of health.

(2) The midwife shall prepare or cause to be prepared the following facilities to be used for delivery:

- (a) The area used for labor shall be cleaned, well lighted, well ventilated and close to the toilet.
- (b) The delivery area should be large enough to allow ample work space and provide privacy.

(c) The delivery area must be organized, well lighted, clean, free from drafts and insects, near handwashing facilities and clear of unnecessary furnishings.

(d) A safe, clean sleeping arrangement for the infant.

(3) The midwife shall instruct the expectant parents and ensure that appropriate supplies are on hand for use by the mother and infant at the time of delivery and early postpartum.

(4) The midwife shall have the following equipment and supplies clean and ready for use at delivery:

- (a) Sterile obstetrical pack.
- (b) Bulb syringe.
- (c) Oxygen.

(d) Eye prophylaxis pursuant to Section 383.04, F.S.

*Specific Authority 467.005 FS. Law Implemented 467.015 FS. History--New 7-14-94, Formerly 61E8-7.006, 59DD-7.006, Amended 9-11-02.*

**64B24-7.007 Responsibilities of Midwives During the Antepartum Period.**

(1) The licensed midwife shall:

(a) Require each patient to have a complete history and physical examination which includes:

1. Pap smear.
2. Serological screen for syphilis.
3. Gonorrhea and chlamydia screening.
4. Blood group including Rh factor and antibody screen.
5. Complete blood count (CBC).
6. Rubella titer.
7. Urinalysis with culture.
8. Sickle cell screening for at risk population.
9. Screen for hepatitis B surface antigen (HBsAG).
10. Screen for HIV/AIDS.

(b) Conduct the Healthy Start Prenatal Screen interview or assure that each patient has been previously screened.

(c) Provide counseling and offer screening related to the following:

1. Neural tube defects.
2. Group B Streptococcus.
3. CVS or genetic amniocentesis for women 35 years of age or older at the time of delivery.
4. Nutritional counseling.
5. Childbirth preparation.
6. Risk Factors.
7. Common discomforts of pregnancy.
8. Danger signs of pregnancy.

(d) Follow-up screening:

1. Hematocrit or hemoglobin levels at 28 and 36 weeks gestation.
2. Diabetic screening between 24 and 28 weeks gestation.
3. Antibody screen for Rh negative mothers, at 28 weeks gestation. Counsel and encourage RhoGAM prophylaxis. In those clients declining RhoGAM prophylaxis repeat antibody screen at 36 weeks.

(e) Require prenatal visits every four weeks until 28 weeks gestation, every two weeks from 28 to 36 weeks gestation and weekly from 36 weeks until delivery.

(2) The following procedures and examinations shall be completed and recorded at each prenatal visit:

- (a) Weight.
- (b) Blood pressure.
- (c) Urine dip stick for protein and glucose each visit with leukocytes, ketones, and nitrites as indicated.
- (d) Fundal height measurements.
- (e) Fetal heart tones and rate.
- (f) Assessment of edema and patellar reflexes, when indicated.
- (g) Indication of weeks' gestation and size correlation.
- (h) Determination of fetal presentation after 28 weeks of gestation.
- (i) Nutritional assessment.
- (j) Assessment of subjective symptoms of PIH, UTI and preterm labor.

(3) An assessment of the Expected Date of Delivery (EDD) and gestational age shall be done by 20 weeks, if practical, according to:

- (a) Last normal menstrual period.
- (b) Reference to the statement of uterine size recorded during the initial exam.

- (c) Hearing fetal heart tones at eleven weeks with a Doppler unit, if one is available, and patient gives consent.
- (d) Recording of quickening date.
- (e) Recording weeks of gestation by dates and measuring in centimeters the height of the uterine fundus.
- (f) Hearing the fetal heart tones at twenty weeks with a fetoscope.
- (4) If a reliable EDD cannot be established by the above criteria, then the licensed midwife shall encourage the patient to have an ultrasound for EDD.
- (5) The midwife shall refer a patient for consultation to a physician with hospital obstetrical privileges if any of the following conditions occur during the pregnancy:
  - (a) Hematocrit of less than 33% at 37th week gestation or hemoglobin less than 11 gms/100 ml.
  - (b) Unexplained vaginal bleeding.
  - (c) Abnormal weight change defined as less than 12 or more than 50 pounds at term.
  - (d) Non-vertex presentation persisting past 37th week of gestation.
  - (e) Gestational age between 41 and 42 weeks.
  - (f) Genital herpes confirmed clinically or by culture at term.
  - (g) Documented asthma attack.
  - (h) Hyperemesis not responsive to supportive care.
  - (i) Any other severe obstetrical, medical or surgical problem.
- (6) The midwife shall transfer a patient if any of the following conditions occur during the pregnancy:
  - (a) Genetic or congenital abnormalities or fetal chromosomal disorder.
  - (b) Multiple gestation.
  - (c) Pre-eclampsia.
  - (d) Intrauterine growth retardation.
  - (e) Thrombophlebitis.
  - (f) Pyelonephritis.
  - (g) Gestational diabetes confirmed by abnormal glucose tolerance test.
  - (h) Laboratory evidence of Rh sensitization.
- (7) If the conditions listed pursuant to this section are resolved satisfactorily and the physician and midwife deem that the patient is expected to have a normal pregnancy, labor and delivery, then the care of the patient shall continue with the licensed midwife.

*Specific Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History--New 7-14-94, Formerly 61E8-7.007, 59DD-7.007, Amended 9-11-02, 7-21-03, 9-18-06.*

**64B24-7.008 Responsibilities of Midwives During Intrapartum.**

- (1) Upon initial assessment, the midwife shall:
  - (a) Determine onset of labor.
  - (b) Review patient's prenatal records.
  - (c) Assess condition of the mother and fetus.
  - (d) Assess delivery environment.
  - (e) Perform sterile vaginal examinations to initially assess cervical dilation and effacement, presentation, position and station of the fetus, and the status of the membranes.
- (2) Throughout active labor the midwife shall:
  - (a) Maintain a safe and hygienic environment.
  - (b) Provide nourishment, rest and support as indicated by patient's condition.
  - (c) Monitor, assess and record the status of labor and the maternal and fetal condition.
  - (d) Measure the blood pressure every hour unless significant changes or symptoms require more frequent assessments.
  - (e) Take the patient's pulse every 2 hours while membranes are intact and temperature is normal, then every hour after rupture of membranes.
  - (f) Take the temperature every 4 hours, or more frequently if maternal condition warrants, and every hour if elevated to 100° F

or above.

(g) Estimate fluid intake and urinary output at least every 2 hours.

(h) Assess for hydration and edema.

(3) The midwife shall assess and record the status of labor as follows:

(a) Measure the frequency, duration and intensity of the contractions every half hour and more frequently if indicated.

(b) Observe and record vaginal discharge.

(c) Monitor fetal heart tones during and following contractions to assess fetal condition according to the following schedule after admission to care for labor:

1. Every hour during the latent phase.

2. Every 30 minutes during the active phase of the first stage.

3. Every 15 minutes during transition.

4. Every five minutes during the second stage.

5. Immediately after the appearance of amniotic fluid in the vaginal discharge.

(d) Palpate the abdomen for the position and level of the presenting part.

(e) Perform sterile vaginal examinations to assess cervical dilation and effacement, presentation, position and station of the fetus, and the status of the membranes.

(4) Risk factors shall be assessed throughout labor to determine the need for physician consultation or emergency transport. The midwife shall consult, refer or transfer to a physician with hospital obstetrical privileges if the following occur during labor, delivery or immediately thereafter:

(a) Premature labor, meaning labor occurring at less than 37 weeks of gestation.

(b) Premature rupture of membranes, meaning rupture occurring more than 12 hours before onset of regular active labor.

(c) Non-vertex presentation.

(d) Evidence of fetal distress.

(e) Abnormal heart tones.

(f) Moderate or severe meconium staining.

(g) Estimated fetal weight less than 2500 grams or greater than 4000 grams.

(h) Pregnancy induced hypertension which is defined as 140/90, or an increase of 30 mm hg systolic or 15 mm hg diastolic above baseline.

(i) Failure to progress in active labor:

1. First stage: lack of steady progress in dilation and descent after 24 hours in primipara and 18 hours in multipara.

2. Second stage: more than 2 hours without progress in descent.

3. Third stage: more than 1 hour.

(j) Severe vulvar varicosities.

(k) Marked edema of cervix.

(l) Active bleeding.

(m) Prolapse of the cord.

(n) Active infectious process.

(o) Other medical or surgical problems.

(5) The midwife shall not perform any operative procedure other than:

(a) Artificial rupture of the membranes when the fetal head is engaged and well applied to the cervix in active labor and four or more centimeters dilated.

(b) Clamping and cutting the umbilical cord.

(c) Episiotomy when indicated.

(d) Suture to repair first and second degree lacerations.

(6) The midwife shall not attempt to correct fetal presentations by external or internal version.

(7) The midwife shall use only prescription drugs pursuant to Rule 64B24-7.011, F.A.C.

(8) The midwife shall not use artificial, forcible or mechanical means to assist the birth.

**64B24-7.009 Responsibilities of the Midwife During Postpartum.**

- (1) Care of the newborn shall include:
  - (a) Clearing the airway of mucus.
  - (b) Clamping and cutting the umbilical cord.
  - (c) Obtaining a cord blood sample for laboratory testing for type, Rh Factor, and direct Coombs test when the mother is Rh negative.
  - (d) Assessing the newborn's condition according to Apgar scoring at one (1) minute and five (5) minutes and record the results of each assessment.
  - (e) Weighing the infant.
  - (f) Instilling prophylaxis into each eye or retain the written objection pursuant to Section 383.04 and 383.06, F.S.
  - (g) Administering vitamin K prophylaxis.
  - (h) Examining the newborn and reporting any abnormalities or problems to the physician including low Apgar score.
  - (i) Providing for infant bonding with parent.
- (2) The midwife shall consult, refer or transfer the infant to a physician if any of the following conditions occur:
  - (a) Apgar score less than 7 at 5 minutes.
  - (b) Signs of pre- or post-maturity.
  - (c) Weight: if less than 2500 grams.
  - (d) Jaundice.
  - (e) Persistent hypothermia, meaning a body temperature of less than 97° F rectal after 2 hours of life.
  - (f) Respiratory problem.
  - (g) Exaggerated tremors.
  - (h) Major congenital anomaly.
  - (i) Any condition requiring more than 4 hours of postdelivery observation.
- (3) Care of the mother shall include:
  - (a) Observation for signs of hemorrhage.
  - (b) Inspection of the expelled placenta to insure that it is intact and free from defects or abnormalities.
  - (c) Palpation of the fundus to insure that it is firm.
  - (d) The midwife shall instruct the mother in self care and care of the infant including feeding and cord care.
- (4) The midwife must remain with the mother and infant for at least 2 hours postpartum, or until both the mother's and infant's conditions are stable, whichever is longer. Maternal stability is evidenced by normal blood pressure, pulse, respirations, bladder functioning, fundus firm and lochia normal. Infant stability is evidenced by established respirations, normal temperature, and strong sucking.
- (5) If any complications arise, such as a retained placenta or postpartum hemorrhage, the midwife shall consult with a physician, or transport the patient for emergency medical care dependent upon the urgency of the situation.
- (6) A follow-up visit shall be made between 24 and 48 hours following delivery, unless conditions warrant an earlier visit. The midwife may arrange for such a visit to be made by a physician, certified nurse midwife, registered nurse, or another licensed midwife. The patient shall be instructed to have a postpartum examination within 6 to 8 weeks after delivery or sooner if any abnormalities exist or problems arise.
- (7) If the mother is Rh negative, the midwife shall obtain the laboratory tests results of the cord blood studies, and if the infant is Rh positive, assure and document that the mother receives Rho immune globulin within 72 hours of the delivery.
- (8) The midwife shall instruct the parents regarding the requirement for the infant screening blood test for metabolic disorders. If arrangements for this screening have not been made, the midwife shall notify the county health unit or retain the written objection pursuant to Section 383.14, F.S.
- (9) The midwife shall conduct the Healthy Start Postnatal Screening for the infant or assure that it will be done.
- (10) Within 5 days following each birth, form DH 511, Certificate of Live Birth, available from the local county health department, must be completed and submitted to the local registrar of vital statistics.
  - (a) For births occurring in a hospital, birth center or other health care facility, or en route thereto, the person in charge of the facility is responsible for the preparation and filing of the certificate, and for certifying the facts of the birth therein. Within 48 hours

of the birth, the midwife shall provide the facility with the medical information required for the birth certificate.

(b) For births occurring outside a facility wherein a licensed midwife is in attendance during or immediately after the delivery, the midwife shall prepare and file the certificate.

*Specific Authority 467.005 FS. Law Implemented 382.013, 467.015 FS. History--New 7-14-94, Formerly 61E8-7.009, Amended 3-20-96, Formerly 59DD-7.009, Amended 9-11-02.*

#### **64B24-7.010 Collaborative Management.**

(1) A midwife may provide collaborative prenatal and postpartal care to women not expected to have a normal pregnancy, labor and delivery with a physician who holds hospital obstetrical privileges maintaining supervision for directing the specific course of medical treatment.

(2) Prior to engaging in collaborative management, the licensed midwife shall:

(a) Provide and document to the department that the midwife successfully completed a course on collaborative management within an approved training program.

(b) Enter into a written protocol with a physician licensed under Chapter 458 or 459, F.S., who is actively practicing obstetrics and has hospital obstetrical privileges. The protocol shall be made on the Collaborative Management Agreement form which is incorporated by reference herein, effective 7-14-94, and can be obtained from the Council of Licensed Midwifery, Department of Health, 4052 Bald Cypress Way, Bin #C06, Tallahassee, Florida 32399-3256 and shall at a minimum contain:

1. Name, address and telephone number of patient.
2. Name, address and telephone number of midwife.
3. Name, address and telephone number of physician who will maintain supervision for directing the specific plan of medical treatment as outlined in the protocol.
4. Identification of factors.
5. Rationale of the deviation from the low-risk criteria.
6. Specific course of management and expected outcome.
7. Criteria for the discontinuance of the collaborative agreement.

(c) The protocol shall be signed and dated by the patient, licensed midwife and physician. A copy of the collaborative agreement shall be placed and maintained in the patient's record.

(d) The midwife shall provide the physician with a complete copy of all patient records pertaining to this pregnancy.

(3) A licensed midwife practicing within a health care facility or under the supervision of a physician group shall establish a written collaborative management protocol prior to providing prenatal and postnatal care to women not expected to have a normal pregnancy, labor, or delivery. The written protocol shall:

- (a) Be maintained on the premises of the health care facility,
- (b) Be updated at least annually,
- (c) Be readily accessible to the midwife and physician,
- (d) Include a plan for access to complete obstetrical services, and
- (e) Be acceptable in lieu of a patient's specific collaborative management agreement.

*Specific Authority 467.005 FS. Law Implemented 467.015(2) FS. History--New 7-14-94, Formerly 61E8-7.010, 59DD-7.010, Amended 9-11-02.*

#### **64B24-7.011 Administration of Medicinal Drugs.**

(1) A midwife licensed prior to October 1, 1992, may administer certain medicinal drugs during intrapartum, postpartum and neonatal care, if prior to administering such drugs, the licensee has successfully completed a course in the practice of administering medicinal drugs within an approved training program.

(2) A midwife may administer only those drugs which have been prescribed by a physician licensed under Chapter 458 or 459, F.S., pursuant to Chapter 499, F.S., and dispensed at a pharmacy permitted by Chapter 465, F.S., and by a pharmacist licensed pursuant to Chapter 465, F.S.

(3) The midwife may administer the following:

- (a) Postpartum oxytocics.
- (b) Prophylactic ophthalmic medication.
- (c) Oxygen.
- (d) Vitamin K.
- (e) RhO Immune Globulin.
- (f) Local anesthetic.
- (g) Other medications as prescribed by the physician.

(4) After administering any medicinal drug, the midwife shall document in the medical record of the patient the type of drug(s) administered, name of drug, dosage, method of administration, injection site, or topical, the date and time, and the drug's effect.

*Specific Authority 467.005 FS. Law Implemented 467.006(2), 467.015(3) FS. History—New 7-14-94, Formerly 61E8-7.011, 59DD-7.011, Amended 9-11-02.*

#### **64B24-7.013 Requirement for Insurance.**

(1) Except as provided herein, applicants for licensure, applicants for licensure reactivation, and applicants for licensure renewal shall at the time of application submit proof of professional liability insurance 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 as defined under Section 624.09, F.S., from a surplus lines insurer as defined under Section 626.914, F.S., from a risk retention group as defined under Section 627.942, F.S., from the Joint Underwriting Association established under Section 627.351(4), F.S., or through a plan of self-insurance as provided in Section 627.357, F.S.

(2) A licensed midwife who practices exclusively as an officer, employee, or agent of the Federal Government or the state or its agencies or subdivisions shall submit proof to the department that coverage equivalent to or exceeding this section is maintained by her employer on her behalf. For purposes of this subsection, an agent of the state, its agencies, or its subdivisions is a person who is eligible for coverage under any self-insurance or insurance program authorized by the provisions of Section 768.28(15), F.S., or who is a volunteer under Section 110.501(1), F.S.

(3) A licensed midwife who practices only in conjunction with teaching duties at an approved midwifery school shall submit proof to the department that coverage equivalent to or exceeding this section is maintained by her employer on her behalf. A licensed midwife may engage in the practice of midwifery only to the extent that such practice is incidental to and a necessary part of duties in conjunction with the teaching position in the school unless the midwife provides proof of coverage as provided by subsection (1) or (2).

(4) A licensed midwife who does not practice midwifery in this state shall submit written proof to the department that the licensed midwife does not practice midwifery and shall be required to submit proof of professional liability coverage as required by this section to the department at least 15 days prior to practicing midwifery in this state.

*Specific Authority 409.908(12), 467.005 FS. Law Implemented 409.908(12), 467.014 FS. History—New 7-14-94, Formerly 59DD-7.013, 61E8-7.013, Amended 5-4-98, 4-26-99, 9-11-02.*

#### **64B24-7.014 Patient Records.**

(1) The midwife shall keep a record of each patient served. Such record shall contain:

- (a) Name, address and telephone number of patient.
  - (b) The informed consent form and all documentation of all care given during the prenatal, intrapartum and postpartum period relevant to midwifery services.
  - (c) The emergency care plan.
  - (d) Documentation of all consultations, referrals, transport, transfer of care and emergency care rendered, and all subsequent updates.
  - (e) A copy of form DH511, Certificate of Live Birth, submitted to the registrar of vital statistics pursuant to Section 467.019(1), F.S.
- (2) The patient's records shall be kept on file for a minimum of 5 years from date of last entry in records.

(3) Patient records are confidential and may not be released unless authorized by the patient in writing. This confidentiality prohibits review of the records by a licensed midwife other than the midwife of record or by other health care providers unless they are actually involved in care or treatment of the patient. Maintenance of patient records by a deceased licensed midwife's estate, authorized agent of the estate or by a successor-owner midwife of a practice does not authorize review of patient records. However, limited review for the purpose of obtaining a patient's name, address and last date of treatment in order to comply with this rule is permitted.

(4) Within 90 days of a midwife's death, the midwife's estate or agent shall place all patient records of the deceased midwife in the care of another Florida licensed midwife.

(a) The patient records of the deceased midwife shall be maintained and made available to patients for a period of 5 years.

(b) Within 90 days of a midwife's death the midwife's estate or agent shall cause a notice to be published in the newspaper of greatest general circulation in the county where the midwife practiced which advises patients of the licensed midwife's death. The notice shall advise patients that they may obtain copies of their medical records and specify the name, address and telephone number of the person from whom the copies of records may be obtained. The notice shall appear at least once a week for four consecutive weeks.

(c) The subsequent Florida licensed midwife shall cause to be published a similar notice whenever the patient records of the deceased midwife are subsequently transferred to another Florida licensed midwife if such transfer is within 5 years of the midwife's death.

(d) During the five year retention period required by this rule each Florida licensed midwife who is in possession of the deceased midwife's patient records shall insure that the original patient records, or in cases where the patient has requested that the records be released or transferred, copies thereof remain in their possession.

(5) Medical records of a licensed midwife who is terminating or relocating their private practice shall be retained by the licensed midwife or their authorized agent, which may be a successor-owner midwife, and made available to patients for 5 years from the date of the last entry in the records.

(6) Within one month of a licensed midwife's termination of practice or relocation of practice outside the local telephone directory service area of their current practice, a notice shall be published in the newspaper of greatest general circulation in the county where the midwife practiced which advises patients of the midwife's termination of practice or relocation. The notice shall advise patients that they may obtain copies of their medical records and specify the name, address and telephone number of the person from whom copies of records may be obtained. The notice shall appear at least once a week for 4 consecutive weeks.

(7) Records shall be made available at a location within the county where the midwife practices or practiced and shall be made available at reasonable times.

(8) When a licensed midwife has been employed by a practice or facility such as a birth center and the laws and rules of that practice/facility maintain that the patients' records belong to the facility, the licensed midwife shall be allowed to review on the premises of the practice/facility the patients records as needed for statistical information pursuant to Sections 467.004(3)(e) and 456.071, F.S., or, the facility may provide the required information in writing to the licensed midwife at reasonable and customary cost to the midwife pursuant to Section 119.08, F.S.

*Specific Authority 467.005 FS. Law Implemented 467.019 FS. History--New 7-14-94, Formerly 61E8-7.014, Amended 3-20-96, Formerly 59DD-7.014, Amended 9-11-02.*

#### **64B24-7.015 Advertising.**

(1) The department permits advertising by licensed midwives regarding the practice of licensed midwifery in accordance with the council's rules so long as such information is in no way fraudulent, false, deceptive or misleading.

(2) No licensed midwife shall disseminate or cause the dissemination of any advertisement or advertising which is in any way false, deceptive, or misleading. Any advertisement or advertising shall be deemed by the department to be false, deceptive, or misleading if it:

(a) Contains a misrepresentation of facts; or

(b) Makes only a partial disclosure of relevant facts; or

(c) Creates false or unjustified expectations of beneficial assistance; or

(d) Appeals primarily to a layperson's fears, ignorance, or anxieties; or



(e) Contains any representation or claims as to which the licensed midwife referred to in the advertising does not expect to perform; or

(f) Contains any representation, statement, or claim which misleads or deceives; or

(g) Could lead a reasonable prudent person to believe that the licensed midwife is licensed to practice medicine when not so licensed in the state of Florida.

(3) As used in the rules of this council, the terms “advertisement” and “advertising” shall mean any statements, oral or written, disseminated to or before the public or any portion thereof, with the intent of furthering the purpose, either directly or indirectly, of selling professional services, or offering to perform professional services, or inducing members of the public to enter into any obligation relating to such professional services.

*Specific Authority 467.005, 467.203(1)(e) FS. Law Implemented 467.203(1)(e) FS. History–New 3-20-96, Formerly 59DD-7.015.*

#### **64B24-7.016 Sexual Misconduct.**

*Specific Authority 467.005, 467.203(1)(f) FS. Law Implemented 467.203(1)(f) FS. History–New 3-20-96, Formerly 59DD-7.016, Repealed 2-18-08.*

#### **64B24-7.018 Address of Record.**

Each licensed midwife shall provide Council staff with either written or electronic notification of one current mailing address. The current mailing address and place of practice is defined as an address acceptable to the United States postal service where the licensed midwife shall be served with notices pertaining to licensure.

*Specific Authority 456.035, 467.005 FS. Law Implemented 456.035 FS. History–New 3-17-09.*

**From:** Barnes, Dana

**To:** Robinson, Christy; "celebratebirthmidwifery@gmail.com"; "Robyn Mattox, Midwife"; "Charlie Rae Young LM, CPM, CLC "; "kathybradley5@yahoo.com"; "tania\_mondesir@yahoo.com"; "Stephanie Wombles CNM"; "R Zachary Pearson-Martinez"; "davestewartmd@gmail.com"

**Subject:** 64B24-7.007

**Date:** Friday, April 17, 2015 1:22:52 PM

*Here are my suggestions for changes to this section, only suggestions of course(!), as a work in progress by all:*

Responsibilities of Midwives During Antepartum:

**The LM shall require every patient to have the following minimum antepartum care, however, if after thorough counseling and discussion the mother refuses one or more components of care, and the midwife determines that care may safely proceed, the midwife may continue providing prenatal care, appropriately documenting any refusal in the health record: (Dr. P-M will need to fix my grammar hereJ)**

**1st trimester (or as early as possible upon entry into care for those entering care late):**

Complete medical, surgical, social, and family history

Complete Physical exam

Ensure Healthy Start Prenatal Screen completed

Assessment for expected date of delivery, if this cannot be accurately determined, refer for ultrasound measurements

Blood pressure measurement at every visit, medical consultation if abnormal

Blood type and Rh(D) antibody screen, medical consultation if Rh sensitization

Hepatitis B screen

HIV test, medical referral if positive

Syphilis screen

Gonorrhea and Chlamydia screen

Urine culture

Tobacco use screen and cessation counseling if positive

Cervical cancer education and screening if indicated

Hemoglobin, medical consultation if <10

Platelet count, medical consultation if <140,000

Folic acid requirement counseling

Nutrition, dietary supplement, and exercise counseling

Herpes Simplex Virus education, medical consultation if active lesions or history of frequent recurrence

### **2nd/3rd Trimesters:**

Blood pressure measurement at every visit, medical consultation if abnormal

Fundal height and Fetal Heart tone measurement at every visit

Antibody screen if Rh(D) negative, administer RhoGAM prophylaxis if negative or medical consultation if positive

Breastfeeding education and counseling

Gestational diabetes screening between 24-28 weeks, medical consultation if positive

Herpes Simplex Virus education, medical consultation to consider prophylaxis if any history

Group B strep screen, between 35-37 weeks, medical consultation if positive

Syphilis, Gonorrhea, Chlamydia, HIV, Hepatitis B screening if at increased risk, referral if appropriate

Visits at least weekly after 36 weeks with determination of fetal presentation, medical consultation if non-vertex presentation

Education regarding risks of post term pregnancy starting at 41 weeks, medical consultation by 42 weeks

**The following additional care is recommended, but may be opted out of after thorough counseling and education regarding potential benefits and risks:**

Pelvic exam

Visits at least every 4-8 weeks until 28 weeks, then every 2-3 weeks until 36 weeks

Maternal weight at every visit

3rd trimester Hemoglobin, medical consultation if  $< 10$

Education regarding available antepartum screening tests for neural tube defects, sickle cell disease, and other genetic abnormalities

Education regarding screening fetal ultrasound

Education regarding maternal vaccinations: influenza, tetanus, pertussis, varicella, and rubella

*Thanks all, Dana B*

**Midwives' Association of Washington State  
INDICATIONS FOR DISCUSSION, CONSULTATION,  
AND TRANSFER OF CARE IN A HOME OR BIRTH CENTER  
MIDWIFERY PRACTICE**

**1. INTRODUCTION:**

Professional members of the Midwives' Association of Washington State (MAWS) include Licensed Midwives (LMs)<sup>1</sup> and Certified Nurse Midwives (CNMs). In the home or birth center setting LMs and CNMs (herein referred to as 'Midwives') work interdependently with one another and with other health care practitioners to promote the optimal health and safety of low-risk mothers and babies during the normal childbearing cycle. Midwives engage in an ongoing risk screening process that begins at the initial visit and continues through the completion of care. In providing care, midwives take into account their clinical judgment and expertise, a client's own values and informed choice, relevant state laws and regulations, the standards for practice and core competencies for basic midwifery care provided by their professional organizations, relevant midwifery and medical literature, the settings in which they practice, the collaborative relationships they have with other health care practitioners and area hospitals, and their philosophy of care.

During pregnancy, labor, or postpartum, risk factors or complications can develop. This document provides a list of conditions that a midwife may encounter in practice for which discussion, consultation, or transfer of care is indicated. The list is representative but not exhaustive. Other circumstances may arise where the licensed midwife believes discussion, consultation, or transfer of care to be necessary.

Professional members of the Midwives' Association of Washington State are advised to discuss, consult, and/or transfer care of their clients according to this document and in accordance with the MAWS document Position Statement: Shared Decision-Making. MAWS recognizes that there are variations in practice specialty and professional members may hold different licenses or qualifications which hold them to a different standard of care than those outlined in this document. (These practitioners may include but are not limited to CNMs, ARNPs, and NDs). In addition, new clinical procedures may be undertaken in accordance with the MAWS document Mechanism for Introducing Expanded Clinical Procedures into Midwifery Practice. MAWS members should discuss the scope and limitations of midwifery care with clients and refer to these documents as necessary.

This document should be used as a screening tool to distinguish between low-risk and higher-risk maternal and newborn clients. Its purpose is to enhance safety and promote midwives' accountability to their clients, to one another, to other health care practitioners, and to the general public. MAWS reviews this document periodically and revises it as necessary in order to reflect the most current evidence available and to insure that the parameters identified promote the safety of mother and newborn without unduly restricting midwifery practice.

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<sup>1</sup> Licensed midwifery, as defined in RCW 18.50, is an autonomous profession. When there are significant deviations from normal during the pregnancy, labor, or postpartum period, licensed midwives are required by law in Washington State (RCW 18.50.010) to consult with a physician regarding the client's care.

## 2. DEFINITIONS:

### 2.1 DISCUSSION WITH ANOTHER MIDWIFE, AN ARNP, OR A PHYSICIAN

A discussion refers to a situation in which the midwife seeks information from a colleague about a clinical situation, presenting a management plan for feedback.<sup>2</sup>

- 2.1.1 It is the midwife's responsibility to initiate a discussion with and provide accurate and complete clinical information to another midwife, a nurse practitioner, or a physician in order to plan care appropriately. This discussion can take place between midwives in the same practice.
- 2.1.2 Discussion should occur in a timely manner soon after the clinical situation is discovered.
- 2.1.3 Discussion may occur in person, by phone, fax, or e-mail.
- 2.1.4 Discussion may include review of relevant patient records.
- 2.1.5 Discussion may include request for prescriptive medication based on signs or symptoms and/or laboratory results.
- 2.1.6 Discussion should be documented by the midwife in her records. Documentation of discussion should refer only to practitioner type without specifying the name of the practitioner contacted. Documentation should also include the midwife's management plan.
- 2.1.7 Discussion need not occur if the midwife has previously encountered a particular situation, discussed it with a colleague, developed a management plan, and is currently managing the same clinical presentation. In this case, documentation of the management plan and discussion with the client of the management plan is sufficient.

### 2.3 CONSULTATION WITH A PHYSICIAN

A consultation refers to a situation in which the midwife, using her professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of a physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the consultation.

- 2.2.1 It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that the midwife is seeking a consultation.
- 2.2.2 A consultation can involve the physician providing advice and information, and/or providing care to the woman/newborn, and/or prescribing treatment for the woman or newborn.

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<sup>2</sup> A MAWS member who has additional credentials (i.e.: CNM, ND) that allow for a broader scope of practice need not discuss conditions that are within her scope of practice.

- 2.2.3 In the case of an in-person consultation, the midwife should expect that the consultant will promptly communicate findings and recommendations to the client and the referring midwife after the consultation has taken place.
- 2.2.4 Where urgency, distance, or climatic conditions do not allow an in-person consultation with a physician when it would otherwise be appropriate, the midwife should seek advice from a physician by phone or other similar means. The midwife should document this request for advice in her records and discuss the consultant's advice with the client.
- 2.2.5 It is the midwife's responsibility to provide all relevant medical records to the consultant, including a written summary of the client's history and presenting problem, as appropriate.
- 2.2.6 Consultation should be fully documented by the midwife in her records, including the consultant's name, date of referral, and the consultant's findings, opinions, and recommendations. The midwife should then discuss the consultant's recommendations with the client.
- 2.2.7 After consultation with a physician, care of the client and responsibility for decision-making, with the informed consent of the client, either continues with the midwife, is shared collaboratively by the midwife and the consultant,<sup>3</sup> or transfers completely to the consultant. Transfer or sharing of care should occur only after dialogue and agreement among the client, the midwife, and the consultant.

## 2.4 TRANSFER TO A PHYSICIAN OR OTHER QUALIFIED HOSPITAL-BASED PROVIDER

When care is transferred permanently or temporarily from the midwife to a qualified hospital-based provider, the receiving practitioner assumes full responsibility for subsequent decision-making, together with the client. For guidance about intrapartum transfers, see also the MAWS document Planned Out-of-Hospital Birth Transport Guideline.

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<sup>3</sup> During such collaborative care the consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. It is the midwife's responsibility to maintain explicitly clear communication between all parties regarding which health professional has primary responsibility for which aspects of the client's care. In addition to any verbal dialogue regarding client care, the dialogue and plan of care should be documented in the client's chart.

### 3.1 PRE-EXISTING CONDITIONS AND INITIAL HISTORY

#### Discussion:

- family history of significant genetic disorders, hereditary disease, or congenital anomalies
- history of pre-term birth (<36 weeks)
- history of IUGR
- history of severe postpartum hemorrhage
- history of severe pre-eclampsia or HELLP
- history of gestational diabetes requiring oral hypoglycemic or insulin
- no prenatal care prior to third trimester
- BMI > 35
- history of lap band, gastroplasty or other bariatric (weight loss) surgery
- previous unexplained neonatal mortality or stillbirth

#### Consultation:

- absent prenatal care at term
- history of seizure disorder in adulthood
- history of HELLP
- history of uterine surgery, including myomectomy
- one prior cesarean birth with low transverse incision
- significant history of or current cardiovascular, renal, hepatic, neurological or severe gastrointestinal disorder or disease
- significant history of or current endocrine disorder (excluding controlled mild hypothyroidism)
- pulmonary disease/active tuberculosis/severe asthma
- collagen vascular diseases
- significant hematological disorders
- current or recent diagnosis of cancer requiring chemotherapy
- history of cervical cerclage
- history of 3 consecutive spontaneous abortions (excluding clients who present to care with viable pregnancy at gestation >14wks and beyond previous miscarriage)
- significant uterine anomalies
- essential hypertension
- history of eclampsia
- history of postpartum hemorrhage requiring transfusion
- current severe psychiatric illness
- current seizure disorder

#### Transfer:

- any serious medical condition associated with increased risk status for mother or fetus, for example: cardiac disease, renal disease with failure, insulin-dependent diabetes mellitus, uncontrolled asthma, or maternal HIV infection
- isoimmunization with an antibody known to cause hemolytic disease of the

newborn

- prior cesarean with incision other than low transverse (e.g. classical)
- two or more prior cesareans with low transverse incision

### 3.2 ANTEPARTUM CONDITIONS

#### Discussion:

- urinary tract infection unresponsive to treatment
- significant abnormal ultrasound finding
- significant abnormal laboratory finding
- unresolved size/dates discrepancies
- 42 completed weeks with reassuring fetal surveillance including AFI and BPP with NST

#### Consultation:

- reportable sexually transmitted infection
- significant abnormal Pap
- significant abnormal breast lump
- pyelonephritis
- thrombosis
- fetal demise after 14 weeks gestation
- anemia unresponsive to treatment
- primary herpes infection
- significant vaginal bleeding
- hemoglobinopathies
- platelets  $\leq 105,000/\mu\text{L}$
- persistent abnormal fetal heart rate or rhythm
- non-reassuring fetal surveillance
- significant placental abnormalities
- significant or unresolved polyhydramnios or oligohydramnios
- presentation other than cephalic at 37 weeks
- multiple gestation if co-managing prenatal care (transfer if not co-managing)
- significant infection the treatment of which is beyond the midwife's scope of practice

#### Transfer:

- ectopic pregnancy
- molar pregnancy
- premature pre-labor rupture of membranes (PPROM)
- documented persistent/unresolved intrauterine growth restriction (IUGR)
- multiple gestation if not co-managing prenatal care
- eclampsia, HELLP, pre-eclampsia, or persistent hypertension
- placenta previa at term
- isoimmunization with an antibody known to cause hemolytic disease of the newborn



- clinically significant placental abruption
- deep vein thrombosis
- cardiac or renal disease with failure
- gestational diabetes requiring management with medication; consultation in lieu of transfer if co-managing metformin with physician
- known fetal anomaly or condition that requires physician management during or immediately after delivery
- 43 weeks completed gestation

### 3.3 INTRAPARTUM CONDITIONS

In certain intrapartum situations, the midwife may need to act immediately and transport may not be the most prudent course of action in that moment. It is expected that the midwife will use her clinical judgment and expertise in such situations, access 9-1-1 and emergency services as appropriate, and transport as able.

#### Discussion:

- >8 hours of active labor pattern without significant change in cervix and/or station and/or position
- >3 hours of active pushing without significant change
- prolonged rupture of membranes (>48 hours without active labor)

#### Transfer:

- active labor before 37 completed weeks
- undiagnosed non-cephalic presentation including breech, transverse lie, oblique lie, or compound presentation at onset of labor
- undiagnosed multiple gestation
- maternal fever ( $\geq 100.4$  F) that persists >1 hour
- findings indicative of chorioamnionitis including, but not limited to, maternal tachycardia, fetal tachycardia, temperature  $\geq 100.4$  F, uterine tenderness, purulent or malodorous amniotic fluid.
- thick meconium
- persistent non-reassuring fetal heart rate pattern
- maternal exhaustion unresponsive to rest/hydration
- abnormal bleeding during labor
- suspected placental abruption
- suspected uterine rupture
- hypertension ( $\geq 140$  systolic or 90 diastolic twice 1 hour apart)
- suspected pre-eclampsia (hypertension and proteinuria)
- maternal seizure
- ROM > 72 hours
- ROM > 18 hours with GBS status unknown and no prophylactic antibiotics, or GBS+ and no prophylactic antibiotics
- prolapsed cord or cord presentation
- significant allergic response

- active genital herpes in vaginal, perineal or vulvar area in labor or after ROM
- client's stated desire for transfer to hospital-based care

### 3.4 POSTPARTUM CONDITIONS

#### Consultation:

- urinary tract infection unresponsive to treatment
- mastitis (including breast abscess) unresponsive to treatment
- reportable sexually transmitted infections
- retained products/unresolved subinvolution/prolonged or excessive lochia
- hypertension presenting beyond 72 hours postpartum
- significant abnormal Pap
- significant postpartum depression

#### Transfer:

- significant postpartum hemorrhage unresponsive to treatment, with or without sustained maternal vital sign instability or shock
- retained placenta (>1 hour or active bleeding and manual removal unsuccessful)
- lacerations beyond midwife's ability to repair
- unusual or unexplained significant pain or dyspnea
- significant, enlarging hematoma
- endometritis
- maternal seizure
- anaphylaxis
- persistent uterine prolapse or inversion
- maternal fever ( $\geq 100.4$  F) that persists > 1 hour within the first 72 hours postpartum
- persistent hypertension in the first 72 hours postpartum ( $\geq 140$  systolic or 90 diastolic twice 1 hour apart)
- postpartum psychosis

### 3.5 NEWBORN CONDITIONS

It is recommended that parents establish a relationship with a pediatric provider before the baby is born. It is strongly recommended that all parents be advised to establish care with a pediatric provider by 2 weeks of age. The following conditions warrant contact sooner.

Consultation:

- low birth weight newborn (< 2500 gm = 5 lbs 8 oz)
- loss of greater than 10% of birth weight
- prolonged asymptomatic jaundice
- persistent cardiac arrhythmias or murmurs
- significant clinical evidence of prematurity
- failure to thrive
- hypoglycemia
- significant or symptomatic jaundice beyond the first 24 hours
- positive critical congenital heart disease screening (CCHD)

Transfer:

- seizure
- jaundice in the first 24 hours
- persistent respiratory distress
- persistent central cyanosis or pallor
- persistent temperature instability
- persistent hypoglycemia
- significant bruising, petechiae or purpura
- Apgar score 6 or less at ten minutes of age
- major congenital anomalies affecting well-being
- birth injury requiring medical attention

**Rule Suggestions for 64B24 - Licensed Midwifery  
By the Midwives Association of Florida 2015**

**64B24-2.004 Licensure by Endorsement.**

The document which renders the foreign trained applicant eligible to practice Obstetrics or midwifery in the country in which that document was issued;

2. The completed midwifery or medical program with a specialty in obstetric equivalent to a three year program, offered the equivalent to 90 credit hours, and included minimum required exposure to course work and practicum areas as demonstrated by use of the Form DH-MQA 1111, 8/07, EVALUATION TOOL – Four Month Pre-Licensure Course Foreign-Trained Midwife Applicant for Licensure By Endorsement, incorporated herein by reference.

(2)(a) Persons trained in another state for licensure by endorsement shall make application to the department pursuant to Rule 64B24-2.001, F.A.C., and shall in addition submit to the department:

**2. A certificate or diploma awarded by a midwifery program which was ACCREDITED BY MEAC OR ACCREDITED BY A ENTITY RECOGNIZED BY THE US DEPARTMENT OF EDUCATION AND was approved by the certifying body of the state in which it was located, or an authenticated copy of that certificate or diploma;**

**64B24-4.010 Four-month Pre-licensure Course.**

(1) The four (4) month pre-licensure course shall be approved by the department and shall include, at a minimum:

(a) Content review and demonstration of proficiency in the core competencies established by the American

College of Nurse Midwives and the Midwives Alliance of North America;

(b) A Florida Laws and Rules Component;

**(c) Provisions for supervised labor, supervised post-partum, supervised newborn exams, and deliveries**

**and supervised prenatal visits equivalent or exceeding the NARM requirements by each course participant**

**with a florida preceptor and completed within the state of Florida.**

**64B24-4.007 Clinical Training.**

(5) The student midwife, during training, shall undertake, under the supervision of a preceptor, the care of 50 women in each of the antepartal, intrapartal and postpartal periods, but the same women need not be seen through all 3 periods. **The student shall undertake, under the supervision of a preceptor 5 vaginal repairs using appropriate suture techniques,** The intrapartum period includes labor, birth, and the immediate postpartum. No more than five percent (5%) of the required intrapartal managements shall include transfers in active labor.

**64B24-4.007 Clinical Training.**

(2) Clinical learning experiences based on program objectives shall include a variety of clinical settings and facilities within the State of Florida such as homes, birth centers, clinics, offices and hospitals. **80% of all clinical experiences must occur under the supervision of a Florida Licensed Midwife and must occur within the state of Florida.**

**64B24-3.005 Initial License Fee.**

The initial license fee whether by examination or endorsement shall be \$500. **If the initial application for licensure is made after the 365 th day of the biennium the fee shall be \$250 for the remainder of the licensing period.**

**64B24-7.001 Definitions.**

As used in this rule chapter, the term:

**(1) "Discussion" A discussion refers to a situation in which the midwife seeks advice or information from a another Licensed midwife, an ARNP, or a physician about a clinical situation, presenting her management plan for feedback.**

**(2) "Consultation" A consultation refers to a situation in which the midwife, using her professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of a physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the consultation. In providing care, licensed midwives and physicians will take into account their patient's own informed choices**

**(3) "Transfer" When care is transferred permanently or temporarily from the midwife to a qualified hospital- based provider, the receiving practitioner assumes full responsibility for subsequent decisionmaking, together with the client.**

**64B24-7.004 Risk Assessment.**

(1) For each patient, the licensed midwife shall assess risk status criteria for acceptance and continuation of care. The general health status and risk assessment shall be determined by the licensed midwife by obtaining a detailed medical history, performing a physical examination, and taking into account family circumstances along with social and psychological factors. The licensed midwife shall risk screen potential patients using the criteria in this section. **These conditions that a licensed midwife may encounter in practice for which discussion, consultation, or transfer of care is indicated. The list is representative but not exhaustive. Other circumstances may arise where the licensed midwife believes discussion, consultation, or transfer of care to be necessary.**

**INDICATIONS:**

**I. Pre-existing Conditions and Initial History**

**Discussion:**

- family history of significant genetic disorders, hereditary disease, or congenital anomalies
- history of pre-term birth (< 36 weeks)

- history of IUGR
- history of severe postpartum hemorrhage
- history of severe pre-eclampsia
- history of gestational diabetes
- history of uterine surgery, including: myomectomy, or prior cesarean birth with subsequent uncomplicated vaginal birth.
- history of asthma
- Congenital heart defects or heart disease assessed by a cardiologist which places the mother or fetus at no risk
- history of postpartum hemorrhage not requiring transfusion

**Consultation:**

- history of uterine surgery, including: myomectomy, or prior cesarean birth without subsequent uncomplicated vaginal birth.
- current or significant history of cardiovascular disease, renal disease, hepatic disorders, neurological disorders, severe gastrointestinal disease
- current or significant history of endocrine disorders (excluding controlled mild hypothyroidism)
- pulmonary disease/active tuberculosis
- collagen-vascular diseases
- significant hematological disorders
- current or significant history of cancer
- history of cervical cerclage
- history of 3 consecutive spontaneous abortions
- significant uterine anomalies
- essential hypertension
- history of eclampsia or HELLP
- previous unexplained neonatal mortality or stillbirth
- isoimmunization with an antibody known to cause hemolytic disease of the newborn
- history of postpartum hemorrhage requiring transfusion
- current mental health problems requiring drug therapy
- no prenatal care prior to third trimester
- history of seizures in the last 2 years or current use of anticonvulsent medications.

**Transfer:**

- absent prenatal care at term
- any serious medical condition, for example: uncontrolled cardiac disease, renal disease with failure, insulindependent diabetes mellitus, or uncontrolled asthma

## **II. Antepartum Conditions**

**Discussion:**

- urinary tract infection unresponsive to treatment
- well-controlled gestational diabetes
- persistent size/dates discrepancies

**Consultation:**

- significant abnormal Pap in the current pregnancy
  - significant abnormal breast lump
  - pyelonephritis
  - thrombosis
  - fetal demise after 14 weeks gestation
  - persistent anemia of < 10 hgb, unresponsive to treatment
  - primary herpes infection
  - significant vaginal bleeding
  - isoimmunization, hemoglobinopathies
  - persistent and/or abnormal fetal heart rate or rhythm
  - significant placental abnormalities
  - documented intrauterine growth restriction
  - unresolved polyhydramnios or oligohydramnios
  - completion of 41 to 42 weeks gestation with reassuring surveillance of fetus
  - presentation other than cephalic at 37 weeks
  - multiple gestation
- persistent gestational hypertension absent of other symptoms**

**Transfer:**

- premature pre-labor rupture of membranes (PPROM)
- HELLP, pre-eclampsia, or eclampsia
- placenta previa 32 weeks gestation
- ectopic pregnancy
- molar pregnancy
- clinically significant placental abruption
- cardiac or renal disease with failure
- uncontrolled gestational diabetes
- known fetal anomaly or condition that requires physician management during or immediately after delivery

**III. Intrapartum Conditions**

**Discussion:**

- arrested active phase of labor (>6 hours of regular, strong contractions without any significant change in cervix and/or station and/or position)
- arrested 2nd stage of labor (2 hours of active pushing without any significant change)

**Consult:**

- arrested 2nd stage of labor (>3 hours of active pushing without any significant change)
- moderate meconium
- ROM > 18 documented without active labor GBS negative mother or GBS positive with tx prophylactic antibiotics



**Transfer:**

- thick meconium
- labor before 37 weeks
- transverse lie, oblique lie
- sustained maternal fever (>100.4 F) or other evidence of maternal infection
- persistent non-reassuring fetal heart rate pattern
- maternal exhaustion unresponsive to rest/hydration
- abnormal bleeding during labor
- suspected placental abruption
- suspected uterine rupture
- pre-eclampsia
- maternal seizure
- ROM >48 hours or ROM >18 hours with unknown GBS status and no prophylactic antibiotics or GBS+ and no prophylactic antibiotics
- prolapsed cord or cord presentation
- significant allergic response
- active genital herpes in vaginal, perineal or vulvar area in labor or after ROM
- client's clear desire for pain relief or hospital transport

**IV. Postpartum Conditions**

**Consultation:**

- subinvolution
- retained products/unresolved subinvolution
- sustained hypertension
- significant abnormal Pap
- postpartum depression
- retained placenta (>1 hour)

**Transfer:**

- significant postpartum hemorrhage unresponsive to treatment, with or without sustained maternal vital sign instability or shock
- retained placenta (90 minutes or active bleeding and manual removal unsuccessful)
- 3th or 4th lacerations, or laceration beyond the ability of the midwife to repair
- unusual or unexplained significant pain or dyspnea
- significant hematoma
- endometritis
- postpartum psychosis
- maternal seizure
- anaphylaxis
- persistent uterine prolapse or inversion

**V. Newborn Conditions**

**Discussion:**

- low birth weight infant ( < 2500 gm = 5 lbs 8 oz)

**Consultation:**

- persistent cardiac arrhythmias or murmurs
- significant clinical evidence of prematurity
- failure to thrive
- hypoglycemia

**Transfer:**

- seizure
- persistent respiratory distress
- persistent central cyanosis or pallor
- persistent temperature instability
- persistent hypoglycemia
- Apgar score less than 7 at five minutes of age and not improving
- major apparent congenital anomalies
- birth injury requiring immediate medical attention
- significant jaundice in first 24 hours or pathologic jaundice at any time

**64B24-7.006 Preparation for Home Delivery.**

(1) For home births, the licensed midwife shall:

(a) Encourage each patient to have medical care available by a health care practitioner experienced in obstetrics

throughout the prenatal, intrapartum and postpartum periods, and

(b) Make a home visit by 36 weeks of pregnancy. The licensed midwife **or her staff** shall ensure that the setting

in which the infant is to be delivered is safe, clean and conducive to the establishment and maintenance of health.

(2) The midwife shall prepare or cause to be prepared the following facilities to be used for delivery:

(a) The area used for labor shall be cleaned, well lighted, well ventilated and close to the toilet.

(b) The delivery area should be large enough to allow ample work space and provide privacy.

(c) The delivery area must be organized, well lighted, clean, free from drafts and insects, near handwashing

facilities and clear of unnecessary furnishings.

(d) A safe, clean sleeping arrangement for the infant.

(3) The midwife shall instruct the expectant parents and ensure that appropriate supplies are on hand for use by

the mother and infant at the time of delivery and early postpartum.

(4) The midwife shall have the following equipment and supplies clean and ready for use at delivery:

(a) Sterile obstetrical pack.

(b) Suction device.

(c) Oxygen

(d) Eye prophylaxis pursuant to Section 383.04, F.S.

(e) !

**64B24-7.007 Responsibilities of Midwives During the Antepartum Period.**

(1) The licensed midwife shall:

(a) Require each patient to have a complete history and physical examination which includes: !

1. HIV
2. Hep B
3. Blood group including Rh factor and antibody screen.
4. Complete blood count (CBC).
5. GBS testing at 36 weeks gestation
6. Other testing as deemed appropriate by the midwife based on risk, assesment or request of patient. !

(b) give the patient informed consent and the right to refuse any screening as per F.S. 381.026

(c) Conduct the Healthy Start Prenatal Screen interview or assure that each patient has been previously screened.

(d) Provide counseling and offer screening related to the following:

1. Neural tube defects.
2. UA with Culture
3. CVS or genetic amniocentesis for women 35 years of age or older at the time of delivery.
4. Nutritional counseling.
5. Childbirth preparation.
6. Risk Factors.
7. Common discomforts of pregnancy.
8. Danger signs of pregnancy.
9. Gonorrhea and chlamydia screening.
10. Rubella titer.
11. Gonorrhea and chlamydia screening.
12. Serological screen for syphilis.
13. Hep C screening

d) Follow-up screening:

1. Hematocrit or hemoglobin levels at 28 and 36 weeks gestation.
2. Diabetic screening between 24 and 28 weeks gestation.
3. Antibody screen for Rh negative mothers, at 28 weeks gestation. Counsel and encourage RhoGAM prophylaxis. In those clients declining RhoGAM prophylaxis repeat antibody screen at 36 weeks.
4. Repeat screenings as per rule 64D-3.042 (Public Health law) 28 and 32 weeks.

(e) Require prenatal visits every four weeks until 28 weeks gestation, every two weeks from 28 to 36 weeks gestation and weekly from 36 weeks until delivery.

(2) The following procedures and examinations shall be completed and recorded at each prenatal visit:

- (a) Weight.
- (b) Blood pressure.
- (c) Urine dip stick for protein and glucose each visit with leukocytes, ketones, and nitrites as indicated.
- (d) Fundal height measurements.
- (e) Fetal heart tones and rate.
- (f) Assessment of edema and patellar reflexes, when indicated.
- (g) Indication of weeks' gestation and size correlation.
- (h) Determination of fetal presentation after 28 weeks of gestation.
- (i) Nutritional assessment.
- (j) Assessment of subjective symptoms of PIH, UTI and preterm labor.

(3) An assessment of the Expected Date of Delivery (EDD) and gestational age shall be done by 20 weeks, if practical, according to:

- (a) Last normal menstrual period.
- (b) Reference to the statement of uterine size recorded during the initial exam.
- (c) **Hearing fetal heart tones at eleven weeks with a Doppler unit, if patient gives consent, or twenty weeks with a fetoscope.**
- (d) Recording of quickening date.
- (e) Recording weeks of gestation by dates and measuring in centimeters the height of the uterine fundus.

!

(4) If a reliable EDD cannot be established by the above criteria, then the licensed midwife shall encourage the patient to have an ultrasound for EDD.

(5) The licensed midwife shall continue to evaluate a patient during the antepartum, intrapartum and postpartum. If the patient has indications for transport pursuant to **64B24-7.004 Risk Assessment** and is not

expected to have a normal pregnancy, labor and delivery, the midwife shall transfer such patient out of his or her

care. The midwife may provide collaborative care to the patient pursuant to Rule 64B24-7.010, F.A.C.

(6) If the conditions listed pursuant to this section are resolved satisfactorily and the physician and midwife

deem that the patient is expected to have a normal pregnancy, labor and delivery, then the care of the patient shall

continue with the licensed midwife.



INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS
The first prenatal visit should be within the first 12 weeks of pregnancy	Visits should be every four weeks *	Visits should be every two weeks*
Complete physical exam, including review of systems	Visit should include: <ul style="list-style-type: none"> <li>• Blood pressure</li> <li>• Weight</li> <li>• Urine for presence of protein and glucose**</li> <li>• Uterine size for progressive growth and consistency with estimated date of delivery (EDC)</li> <li>• Fetal heart rate</li> <li>• Fetal movement assessment</li> </ul>	Visit should include: <ul style="list-style-type: none"> <li>• Blood pressure</li> <li>• Weight</li> <li>• Urine for presence of protein and glucose**</li> <li>• Uterine size for progressive growth and consistency with estimated date of delivery (EDC)</li> <li>• Fetal heart rate</li> <li>• Fetal movement assessment</li> </ul>
Complete medical history of expectant mother including menstrual history and previous pregnancies	Assessed at the first visit	Assessed at the first visit
Genetic screening/counseling of expectant mother and father and any pertinent family history	Assessed at the first visit	Assessed at the first visit
Lab tests: <ul style="list-style-type: none"> <li>• Blood group and RH type</li> <li>• Antibody screen</li> <li>• Complete blood count</li> <li>• Varicella</li> <li>• Rubella</li> </ul>	Lab tests (when indicated) <ul style="list-style-type: none"> <li>• Repeat antibody tests in unsensitized, D-negative patient at 28-29 weeks and prophylactic anti-D immune globulin should be administered.</li> <li>• Screen for gestational diabetes</li> </ul>	Lab tests: <ul style="list-style-type: none"> <li>• Hct/Hgb</li> <li>• Screen at 35-37 wks for Group B strep</li> </ul> Additional Lab tests (when indicated): <ul style="list-style-type: none"> <li>• Ultrasound</li> </ul>



INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS
<ul style="list-style-type: none"> <li>• VDRL/RDR (syphilis)</li> <li>• Urinalysis</li> <li>• Urine culture &amp; sensitivity</li> <li>• Chlamydia Screen</li> <li>• Hepatitis B surface antigen</li> <li>• Cervical cytology (as needed)</li> <li>• Human immunodeficiency virus (HIV) counseling/testing (offered)</li> </ul>	<p>mellitus at 24-28 wks</p> <ul style="list-style-type: none"> <li>• Repeat hematocrit &amp; hemoglobin</li> <li>• The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit, if later.</li> </ul>	<ul style="list-style-type: none"> <li>• VDRL</li> <li>• Gonorrhea</li> <li>• Chlamydia (Women younger than 25yrs or at high risk)</li> <li>• HIV (Women at high risk for HIV)</li> </ul>
<p>Optional lab test offered or recommended based on history: (May not be all inclusive)</p> <ul style="list-style-type: none"> <li>• Hemoglobin Electrophoresis</li> <li>• PPD</li> <li>• Gonorrhea</li> <li>• Screen for Cystic Fibrosis</li> <li>• Tay-Sachs Genetic screening tests</li> <li>• Ultrasound at 8-10 weeks (when indicated)</li> <li>• Prenatal genetic diagnosis</li> <li>• Mantoux tuberculin skin test or interferon -gamma release assay</li> </ul>	<p>Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.</p>	<p>Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.</p>
<ul style="list-style-type: none"> <li>• 1st trimester aneuploidy risk assessment</li> <li>• MSAFP/multiple markers**</li> <li>• Patients at increased risk of aneuploidy can be offered</li> </ul>	<p>Integrated screening or sequential screening should be offered to women who seek prenatal care in the first trimester.</p>	



INITIAL EVALUATION	UP TO 20 WEEKS	20-36 WEEKS
<p>testing with cell free fetal DNA after pretest counseling and informed patient choice (Cell free fetal DNA testing should not be part of routine prenatal laboratory assessment, nor should it be offered to low risk women or women with multiple gestation)</p> <p><b>**All women presenting for prenatal care before 20 weeks of gestation should be offered screening for aneuploidy.</b></p> <p>All women, regardless of age, should have the option of invasive prenatal diagnosis (ie, CVS or amniocentesis) for fetal aneuploidy.</p> <p>Cell free fetal DNA does not replace the accuracy and diagnostic precision of prenatal diagnosis with CVS or amniocentesis, which remain an option for women.</p>	<p>Integrated screening uses both the first-trimester and second-trimester markers. Results are reported only after both first- and second-trimester screening tests are completed. In sequential screening, the patient is informed of the first-trimester screening result. Those at highest risk might opt for an early diagnostic procedure and those at lower risk can still take advantage of the higher detection rate achieved with additional second-trimester screening.</p> <ul style="list-style-type: none"><li>• First-trimester combined serum screening (pregnancy associated plasma protein-A and free B-hCG) with nuchal translucency measurement (10-13 weeks of gestation)</li><li>• Second-trimester triple (alpha-fetoprotein (AFP), estriol, B-hCG) or Quadruple (AFP,estriol, B-hCG, inhibin-A) marker serum screening (15- 20 weeks of gestation)</li><li>• The options for women who are first seen during the second trimester are limited to quadruple (or "quad") screening and ultrasound examination.</li><li>• First trimester nuchal translucency testing alone for multiple gestations (Serum screening tests are not as sensitive in multiple gestations)</li></ul>	



INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS
	<ul style="list-style-type: none"><li>• If nuchal translucency measurement is not available or cannot be obtained in an individual patient, a reasonable approach is to offer serum integrated screening to patients who present early and second-trimester screening to those who present later.</li><li>• Women found to be at increased risk of aneuploidy with first-trimester screening should be offered genetic counseling and option of CVS or second trimester amniocentesis.</li><li>• Indications for Considering the Use of Cell Free Fetal DNA:<ul style="list-style-type: none"><li>• Maternal age 35 years or older at delivery;</li><li>• Fetal ultrasonographic findings indicating an increased risk of aneuploidy;</li><li>• History of a prior pregnancy with a trisomy;</li><li>• Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen;</li><li>• Parental balanced robertsonian translocation with increased risk of fetal trisomy 13 or trisomy 21.</li></ul></li></ul>	





INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS
<p>Counsel regarding:</p> <ul style="list-style-type: none"><li>• Prenatal Vitamins and folic acid</li><li>• HIV and other prenatal tests</li><li>• Risk factors identified by history</li><li>• Anticipated course of prenatal care</li><li>• Nutrition and weight gain</li><li>• Toxoplasmosis precautions</li><li>• Sexual Activity</li><li>• Exercise</li><li>• Seasonal Influenza vaccine (All pregnant women, regardless of trimester, should receive the inactivated influenza vaccination during the flu season)</li><li>• Other vaccines recommended in pregnancy, if indicated, include Tdap, hepatitis A, Hepatitis B, and pneumococcal (recommended for pregnant women with prior splenectomy or functional asplenia). According to CDC, pregnancy should not preclude vaccination with meningococcal polysaccharide vaccine, if indicated.</li><li>• Smoking counseling</li><li>• Environmental/work hazards</li><li>• Travel</li></ul>	<p>Counsel regarding:</p> <ul style="list-style-type: none"><li>• Signs &amp; symptoms of preterm labor</li><li>• Abnormal lab values</li><li>• Injectable Influenza vaccine (for all pregnant women who will be pregnant during the influenza season)</li><li>• Selection of pediatrician</li><li>• Smoking counseling</li><li>• Postpartum family planning/tubal sterilization</li></ul>	<p>Counsel regarding:</p> <ul style="list-style-type: none"><li>• Anesthesia/analgesia plans</li><li>• Fetal movement monitoring</li><li>• Labor signs</li><li>• VBAC counseling (if indicated)</li><li>• Signs &amp; symptoms of pregnancy induced hypertension</li><li>• Post term counseling</li><li>• Circumcision</li><li>• Breast or bottle feeding</li><li>• Postpartum depression</li><li>• Influenza vaccine</li><li>• Smoking counseling</li><li>• Domestic Violence</li><li>• Newborn education</li><li>• Family medical leave</li></ul>



INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS
<ul style="list-style-type: none"><li>• Tobacco use</li><li>• Alcohol use</li><li>• Illicit/recreational drugs</li><li>• Use of any medications (supplements, OTC etc)</li><li>• Indications for ultrasound</li><li>• Domestic violence</li><li>• Seat belt use</li><li>• Childbirth classes and choosing newborn care provider</li><li>• Air travel during pregnancy</li><li>• Umbilical cord blood banking</li><li>• Breastfeeding (promote &amp; support)</li><li>• Circumcision</li><li>• Vaginal Birth after Cesarean delivery (VBAC)</li><li>• Newborn screening</li><li>• Dental care in pregnancy</li></ul>		

\*The frequency of follow up visits is determined by the individual needs of the woman and assessment. Women with medical or obstetric problems, as well as women at the extremes of reproductive age, require closer surveillance.

\*\*Inclusion of routine dipstick assessment for all pregnant women can be modified. A baseline urinalysis to assess renal status is recommended. However, in the absence of risk factors for urinary tract infection, renal disease and preeclampsia (such as diabetes, hypertension, and autoimmune disorders) ; symptoms of urinary tract infection, hypertension or unusual edema, there has not been shown to be a benefit to routine dipstick testing during prenatal care for women at low risk.

**Postpartum Visit:**

4-6 weeks after delivery but may be modified according to the needs of the patient. A visit within 7-14 days after delivery for cesarean delivery or complicated gestation.



Postpartum review should include:

- Interval history
- Physical exam
- Pap smear if indicated
- Review of family planning/birth control/preconceptional care
- Screen for depression
- Review of immunization status and recommendations as necessary

### **Preconception Care:**

Consists of the identification of those conditions that could affect a future pregnancy or fetus and that may require intervention. Counseling to optimize pregnancy outcomes should include:

- Family planning and pregnancy spacing
- Family HX
- Genetic history (both maternal and paternal)
- Medical, surgical, and psychiatric history
- Current medication (prescription and non prescription)
- Substance use, including alcohol, tobacco and recreational and illicit drugs
- Exposure to violence and intimate partner violence
- Nutrition
- Teratogen; Environmental and occupational exposures
- Immunity and immunization status and offer vaccine if indicated (influenza, measles, mumps, rubella A & B, meningococcus and pneumococcus). The HPV vaccine can be offered to appropriate non-pregnant women. However, the vaccine is not recommended during pregnancy, completion of the vaccine series may be recommended postpartum period. Avoiding pregnancy within 1 month of receiving a live attenuated viral vaccine is recommended.
- Risk factors for sexually transmitted diseases
- Obstetric history
- Gynecologic history
- General physical exam
- Assessment of socioeconomic, educational and cultural context
- Testing for specific diseases can be performed when indicated such as with genetic disorders.

Patients should be counseled regarding exercise, weight, nutrition, prevention of HIV infection, abstain from alcohol and illicit drugs use before and during pregnancy, determining the time of conception by accurate menstrual cycles, and taking 0.4mg - 0.8 mg daily while attempting pregnancy and during three months of pregnancy for prevention of neural tube defects.



and maintaining good control of any preexisting conditions. Based on racial and ethnic background, screening disorders may be performed.

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13. ACOG Practice Bulletin. Gestational Diabetes Mellitus. Number 137. August 2013
14. The American College of Obstetricians and Gynecologists Committee on Genetics. The Society for Maternal and Fetal Medicine. Publications Committee. Committee Opinion Number 581. The Use of Chromosomal Microarray Analysis for Prenatal Diagnosis. Dec 2013
15. American College of Obstetricians and Gynecologists Committee Opinion. Influenza Vaccination During Pregnancy. Number 608. Sept 2014 (Replaces No. 468, October 2010)



Health Net

2015 Prenatal/Perinatal Health Guidelines

Important Note

Health Net's Prenatal/Perinatal Health Guidelines provide recommendations are for the general population, based on the best time of release. A Health Net member's medical history and physical examination may indicate that further medical tests are from state to state based on state regulations and requirements. As always, the judgment of the treating physician is the final. benefit plan may or may not cover all the services listed here. Please refer to your certificate of coverage for complete details. number listed on your ID card.

Review History: February 2007, February 2008, March 2009, February 2010, February 2011, February 2012, February 2013, February 2014, February 2015

**64B24-1.004 Terms, Meetings, Quorum, and Absences.**

(1) Council members are appointed for staggered terms of four years and each may be reappointed for one additional consecutive term. The Surgeon General shall determine the date of the appointment for purposes of staggering the terms.

(2) The council shall hold such meetings during the year as it may deem necessary, one of which shall be the annual meeting at which the chairperson and vice-chairperson shall be elected. The department, the chairperson or a quorum of the council shall have the authority to call other meetings.

(23) Fifty one percent (51%) or more of the appointed members of the council shall constitute a quorum necessary to transact business. The business of the council shall be conducted according to *The Standard Code of Parliamentary Procedure*.

(34) Three consecutive unexcused absences, or absences constituting 50 percent or more of the council's meetings within any 12 month period shall cause the council membership of the member in question to become void, and the position shall be considered vacant pursuant to Section 456.011(3), Florida Statutes. For the purposes of this rule, an absence shall be deemed unexcused if the council member member's has not received approval of the Chair or the Chair's designee prior to missing the meeting absence is caused by a health problem or condition verified in writing by a physician, or by an accident or similar unforeseeable tragedy or event, and the council member submits to the Executive Director a statement in writing attesting to the event and its circumstances prior to the next council meeting.

*Rulemaking Authority 467.005 FS. Law Implemented 456.011(3), 467.004 FS. History—New 1-26-94, Formerly 61E8-1.004, 59DD-1.004, Amended 11-21-02,\_\_\_\_\_.*

**64B24-1.005 Annual Report.**

The council shall prepare an annual report by November 1 for the preceding fiscal year which shall contain information including, but not limited to, major activities, rule recommendations, council meetings, educational efforts and activities, status of midwifery practice in other states, safety recommendations, and a review of the data elements collected from the annual midwife reports. A fiscal year begin on July 1 of each year and ends June 30 of the succeeding year.

*Rulemaking Authority 467.005 FS. Law Implemented 456.026, 467.004 FS. History—New\_\_\_\_\_.*

#### **64B24-2.001 Licensure to Practice Midwifery.**

(1) ~~Applications for a midwife license~~ Persons desiring to be licensed as a midwife shall be submitted ~~make application to the department on the appropriate form, and remit all applicable fees as required by Chapter 64B24-3, F.A.C. The application shall be made on incorporated by reference Form DH MQA 1051, (3/10) Application for Midwifery Licensure, which can be obtained from the Council of Licensed Midwifery, Department of Health, 4052 Bald Cypress Way, Bin C06, Tallahassee, Florida 32399 3256 or at <http://www.doh.state.fl.us/mqa/midwifery>. If incomplete the application and fees shall expire 1 year from the date on which the application is initially received by the department. After a period of 1 year a new application with required fees must be submitted.~~

(2) Applicants must ~~The department shall license only those applicants who have completed the application form, remitted the appropriate fees required by Rule Chapter 64B24-3, F.A.C., and who demonstrate to the department that they:~~

(a) Are 21 years of age or older;

(b) Meet the requirements for licensure by examination ~~exam~~ ~~pursuant to Rule 64B24-2.003, F.A.C., or licensure by endorsement pursuant to Rule 64B24-2.004, F.A.C.;~~

(c) Have completed a one hour educational course on HIV/AIDS that meets the substantive specifications set forth in Section 381.0034, F.S., as it pertains to the practice of midwifery; ~~and~~

(d) Have completed a two hour course relating to the prevention of medical errors; ~~and~~

~~(3e) Have successfully completed an approved four-month precicensure course, if required. Applications to the Department shall be accepted from persons desiring to be licensed as a midwife by endorsement and needing to establish educational eligibility for acceptance into the required 4 month precicensure course. The application shall be made on Form DH MQA 1113, 8/07, Application For 4 Month Pre Licensure Course, incorporated herein by reference, which can be obtained from the Council of Licensed Midwifery, Department of Health, 4052 Bald Cypress Way, Bin C06, Tallahassee, Florida 32399 3256. Unless the Department has reason to believe that mistaken or fraudulent documentation was relied upon or unless requested by an applicant, the educational eligibility determination for purposes of the 4 month precicensure course also shall be used to determine educational eligibility for purposes of the subsequent licensure by endorsement application.~~

(4) ~~When the department is satisfied that all requirements are met in full, a license to practice midwifery will be issued to the applicant. The license will remain valid for the remainder of the biennium in which it is issued, unless suspended or revoked by the department.~~

*Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 381.0034, 456.013, 467.011, 467.0125 FS. History—New 1-26-94, Formerly 61E8-2.001, 59DD-2.001, Amended 10-29-02, 12-26-06, 2-7-08, 5-17-09, 8-10-10,\_\_\_\_\_.*

#### **64B24-2.0011 Forms.**

(1) Applications for licensure by examination or endorsement shall be on form DH-MQA 1051, “Application for Midwifery Licensure”, (###/##), which is adopted and incorporated herein by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-#####>.

(2) Applicatons for a temporary certificate to practice midwifery in areas of critical need shall be on form DH-MQA #####, “Application for Temporary Midwifery Certificate in Areas of Critical Need”, (#####), which is adopted and incorporated herein by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-#####>.

(3) Applications to reactivate an inactive license shall be on form DH-MQA #####, “Application for Reactivation”, (#####), which is adopted and incorporated herein by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=ref-#####>.

(4) Evaluation tools shall be used by foreign trained midwives or midwives licensed in other states to demonstrate equivalency. The evaluation tools are contained in the forms below, which are adopted and incorporated by reference.

(a) DH-MQA 1111, “Foreign-Trained Midwife Applicant Evaluation Tool,” (###/##), available at <http://www.flrules.org/Gateway/reference.asp?No=Ref#####>.

(b) DH-MQA 1112, "Out of State Midwife Applicant Evaluation Tool", (##/##), available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-#####>.

*Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.011, 467.0125, FS. History–New \_\_\_\_\_.*

#### **64B24-2.002 Examination.**

The department hereby designates the North American Registry of Midwives' (NARM) written examination ~~dated after October 1, 1993,~~ as the midwifery licensure examination. Any person desiring to be licensed as a midwife shall apply and pay the examination fee to the NARM to take the licensure examination.

*Specific Rulemaking Authority 456.004, 467.005, 456.017 FS. Law Implemented 467.011, 456.017 FS. History–New 1-26-94, Formerly 61E8-2.002, Amended 9-3-95, Formerly 59DD-2.002, Amended 9-26-02, \_\_\_\_\_.*

#### **64B24-2.003 Licensure by Examination.**

In addition to the application, Ppersons desiring to obtain seeking licensure as a midwife by examination shall make application to the department pursuant to Rule 64B24 2.001, F.A.C., and shall evidence compliance of licensure requirements by submit submitting the following:

(1) An official transcript from an approved midwifery training program specifically setting forth all courses successfully completed, the date of the applicant's graduation and the degree, certificate, or diploma awarded;

(2) A general written emergency care written plan for the management of emergencies which meets the requirements of Section 467.017(1), F.S., and submitted on Form DH MQA 1077 (10/05), Emergency Back Up Plan for Licensed Midwifery Patients, incorporated herein by reference, and

(3) Documentation of a passing score on the licensure examination ~~designated in Rule 64B24 2.002, F.A.C.~~ Such documentation shall be sent directly to the department from the NARM.

*Specific Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 456.017, 467.011, 467.017 FS. History–New 1-26-94, Formerly 61E8-2.003, 59DD-2.003, Amended 10-24-02, 2-2-06, \_\_\_\_\_.*

#### **64B24-2.004 Licensure by Endorsement.**

(1) (a) In addition to the application, Fforeign trained applicants for licensure as a midwife by endorsement shall make application to the department pursuant to Rule 64B24 2.001, F.A.C., and shall in addition submit to the department following:

1. A valid certificate or diploma from either a foreign institution of medicine or a foreign school of midwifery;

2. A certified translation of the certificate or diploma earned from a foreign institution of medicine or foreign school of midwifery;

3. The document which renders the foreign trained applicant eligible to practice medicine or midwifery in the country in which that document was issued;

4. A 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;

5. Explanation Clarification of the existence of any deviation as to how the applicant's name appears on the face of different names on documents in support of this submitted with the application;

6. Evidence of successful completion of ~~the an approved~~ 4 month prelicensure course ~~pursuant to Rule 64B24-4.010, F.A.C.;~~

7. Evidence of a passing score on the licensure examination; and

8. A general written emergency care plan for the management of emergencies which meets the requirements described in Section 467.017, F.S.

(b) In determining whether the requirements to hold a certificate or diploma from a foreign institution of medicine or a foreign school of midwifery are substantially equivalent to the requirements established under Chapter 467, F.S., and these rules, the department shall consider whether:

1. The applicant has a high school diploma, or its equivalent, and passed the College-Level Academic Skills Test (CLAST), or has taken and received a passing grade in three college level credits each of Math and English, or



can demonstrate competencies in communication and computation by passing the College-Level Examination Program (CLEP) test in communication and computation.

2. The completed midwifery or medical program equivalent to a three year program, offered the equivalent to 90 credit hours, and included minimum required ~~exposure to~~ course work and practicum areas as demonstrated by use of the appropriate evaluation tool Form DH MQA 1111, 8/07, EVALUATION TOOL—Four Month Pre-Licensure Course Foreign Trained Midwife Applicant for Licensure By Endorsement, incorporated herein by reference.

3. The applicant has received a determination of substantial equivalency through the use of this evaluation tool by an approved foreign education credentialing agency, ~~meeting the following criteria:~~

~~a. Has a comprehensive, standardized orientation and training program for all reviewers who must be experienced and knowledgeable in the area of midwifery education.~~

~~b. Has an audit and quality assurance or review committee to monitor the evaluation process.~~

~~c. Employs full time staff support including an international expert in education credential equivalency and analysis.~~

~~d. Has an updated, current, and comprehensive resource document library available for reference.~~

~~e. Consults with a Florida licensed midwife approved by the Department to review the professional education component of the review.~~

~~f. Uses original documentation for the institution with institutional seals and signatures.~~

(2)(a) In addition to the application, ~~Persons trained in another state for seeking licensure as a midwife by endorsement shall make application to the department pursuant to Rule 64B24 2.001, F.A.C., and shall in addition submit to the department following:~~

1. Evidence of successful completion of the approved 4- four month prelicensure course pursuant to Rule 64B24 4.010, F.A.C.;

2. Evidence of a passing score on the licensure examination; and

3. A general written emergency care plan for the management of emergencies which meets the requirements described in Section 467.017, F.S.

(b) In determining whether the requirements to hold a certificate or license to practice midwifery in another state are substantially equivalent to the requirements established under Chapter 467, F.S., and these rules, the applicant shall submit:

1. A current valid unrestricted certificate or license to practice midwifery in another state;

2. A certificate or diploma awarded by a midwifery program which was approved by the certifying body of the state in which it was located, or an authenticated copy of that certificate or diploma;

3. A copy of the other state's laws and rules under which the applicant's certificate or license was issued; and

4. Official transcripts from the midwifery program which document classroom instruction and clinical training equivalent to the requirements in ~~Rules 64B24 4.004 through 64B24 4.007, F.A.C~~ these rules.

(c) In determining whether the requirements to practice midwifery in another state are substantially equivalent to the requirements established under Chapter 467, F.S., and these rules, the department shall consider whether:

1. The applicant has a high school diploma, or its equivalent, and passed the College Level Academic Scholastic Test (CLAST), or has taken and received a passing grade in three college level credits each of Math and English, or can demonstrate competencies in communication and computation by passing the College Level Equivalent Proficiency (CLEP) test in communication and computation.

2. The completed midwifery or medical program equivalent to a three year program, offered the equivalent to 90 credit hours, and included minimum required ~~exposure to~~ course work and practicum areas as demonstrated by use of the appropriate evaluation tool Form DH MQA 1112, 8/07, EVALUATION TOOL—Four Month Pre-Licensure Course Out of State Midwife Applicant for Licensure By Endorsement, incorporated herein by reference.

3. The applicant has received a determination of substantial equivalency through the use of this evaluation tool by an approved education credentialing agency, ~~meeting the following criteria:~~

~~a. Has a comprehensive, standardized orientation and training program for all reviewers who must be experienced and knowledgeable in the area of midwifery education.~~

- ~~b. Has an audit and quality assurance or review committee to monitor the evaluation process.~~
- ~~c. Employs full time staff support including an international expert in education credential equivalency and analysis.~~
- ~~d. Has an updated, current, and comprehensive resource document library available for reference.~~
- ~~e. Consults with a Florida licensed midwife approved by the department to review the professional education component of the review.~~
- ~~f. Uses original documentation for the institution with institutional seals and signatures.~~

~~(3)(a)~~ The department shall issue a temporary certificate to practice midwifery in areas of critical need to any applicant who is qualifying for licensure by endorsement pursuant to ~~subsection 64B24 2.004(1) or (2), F.A.C Chapter 467 and these rules.~~ The applicant shall submit to the department:

~~1. A completed application and the required temporary certificate fee required pursuant to Rule 64B24 3.004, F.A.C.;~~

~~2. Documentation as required by paragraph (1)(a) or (2)(a) of this rule which will evidence the active pursuit of licensure through endorsement;~~

~~3. Documentation of the area of critical need pursuant to Section 467.0125(2)(a), F.S.; and the~~

~~4. Name of the individual who will serve as the midwife's supervisor. This individual shall be a physician currently licensed pursuant to Chapter 458 or Chapter 459, F.S., a certified nurse midwife licensed pursuant to Chapter 464, F.S., or a midwife licensed pursuant to Chapter 467, F.S., who has a minimum of 3 years of professional experience.~~

~~(b) A temporary certificate issued under this section 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. A temporary certificate is not renewable, nor shall a person be granted a temporary certificate more than once.~~

~~(4)(e)~~ To ascertain that the minimum requirements of the midwifery rules are being met, temporary certificate holders shall submit an annual report by December 1 of each year on Form DH-MQA 1052, "Annual Report of Midwifery Practice", (###/##), adopted and incorporated herein by reference, available at <http://www.flrules.org/gateway/reference.asp?No=ref-####> and revised 8/01, and can be obtained from the Council of Licensed Midwifery, Department of Health, 4052 Bald Cypress Way, Bin C02, Tallahassee, Florida 32399 3256.

*Rulemaking Authority 467.005 FS. Law Implemented 467.0125 FS. History—New 1-26-94, Formerly 61E8-2.004, 59DD-2.004, Amended 10-24-02, 2-7-08, 4-22-09,\_\_\_\_\_.*

**64B24-3.002 Application Fees.**

- (1) The application fee shall be \$200.
- (2) The 4-month prelicensure course application fee shall be \$100.
- (3) The examination fee shall be paid to the examination vendor and refunded if the applicant is ineligible to sit for the examination.
- (4) The endorsement fee shall be \$250.
- (5) The initial licensure fee shall be \$500, whether by examination or endorsement.
- (6) The temporary certificate fee shall be \$50 in addition to the fee required for licensure.
- (7) The active biennial renewal fee shall be \$500.
- (8) The delinquent fee shall be \$75.
- (9) The reactivation fee shall be \$500.
- (10) The duplicate license fee shall be \$25.
- (11) The continuing education provider application fee shall be \$250.
- (12) The change of status fee shall be \$75.
- (13) The inactive status renewal fee shall be \$500.
- (14) The retired status fee shall be \$50.

*Rulemaking Authority 467.005, 467.0135 FS. Law Implemented 456.036(4), 467.0135(4) FS. History—New 1-26-94, Formerly 61E8-3.002, Amended 8-15-95, Formerly 59DD-3.002, Amended 12-23-97, 11-9-05, 5-4-06, 11-8-07,\_\_\_\_\_.*

**64B24-3.003 Examination Fee.**

The examination fee shall be \$500. This fee shall be refunded if the applicant is ineligible to sit for the examination.

*Rulemaking Authority 467.005 FS. Law Implemented 467.0135(1) FS. History—New 1-26-94, Formerly 61E8-3.003, Amended 8-15-95, 8-20-97, Formerly 59DD-3.003, Repealed\_\_\_\_\_.*

**64B24-3.004 Endorsement Fee.**

The endorsement fee shall be \$250.

*Rulemaking Authority 467.005, 467.0135 FS. Law Implemented 467.0135(6) FS. History—New 1-26-94, Formerly 61E8-3.004, Amended 8-15-95, Formerly 59DD-3.004, Amended 12-23-97, 11-10-99, 5-2-10, Repealed\_\_\_\_\_.*

**64B24-3.005 Initial License Fee.**

The initial license fee whether by examination or endorsement shall be \$500.

*Rulemaking Authority 467.005 FS. Law Implemented 467.0135(2) FS. History—New 1-26-94, Formerly 61E8-3.005, Amended 8-15-95, Formerly 59DD-3.005, Amended 11-10-99 Repealed\_\_\_\_\_.*

**64B24-3.006 Temporary Certificate Fee.**

The temporary certificate fee shall be \$50 and shall be in addition to the fee required for licensure.

*Rulemaking Authority 467.005 FS. Law Implemented 467.0125(2)(f) FS. History—New 1-26-94, Formerly 61E8-3.006, Amended 8-15-95, Formerly 59DD-3.006, Repealed\_\_\_\_\_.*

**64B24-3.007 Active Biennial Renewal Fee.**

The active biennial renewal fee shall be \$500.

*Rulemaking Authority 467.005, 467.0135 FS. Law Implemented 467.0135(3) FS. History—New 1-26-94, Formerly 61E8-3.007, Amended 8-15-95, Formerly 59DD-3.007, Amended 12-23-97, 11-10-99, Repealed\_\_\_\_\_.*

**64B24-3.008 Delinquent Fee.**

The delinquent fee shall be \$75.

*Rulemaking Authority 456.036 FS. Law Implemented 456.036 FS. History--New 1-26-94, Formerly 61E8-3.008, Amended 8-15-95, Formerly 59DD-3.008, Repealed.*

**64B24-3.009 Reactivation Fee.**

The reactivation fee shall be \$500.

*Rulemaking Authority 467.005, 467.0135(3) FS. Law Implemented 467.0135 FS. History--New 1-26-94, Formerly 61E8-3.009, Amended 8-15-95, Formerly 59DD-3.009, Amended 12-23-97, Repealed.*

**64B24-3.011 Duplicate License Fee.**

The duplicate license fee shall be \$25.

*Rulemaking Authority 456.025, 467.005 FS. Law Implemented 456.025(10) FS. History--New 1-26-94, Formerly 61E8-3.011, Amended 8-15-95, Formerly 59DD-3.011, Repealed.*

**64B24-3.013 Continuing Education Provider Application Fee.**

The provider application fee shall be \$250.

*Rulemaking Authority 456.004(5) FS. Law Implemented 456.025(4) FS. History--New 8-15-95, Formerly 59DD-3.013, Repealed.*

**64B24-3.014 Unlicensed Activity Fee.**

Pursuant to the provision of Section 456.065(3), Florida Statutes, a special fee of \$5 shall be imposed upon any initial license or certificate issued by the agency, as well as upon any renewal of said license or certificate, and shall fund efforts to combat unlicensed activity.

*Rulemaking Authority 456.065(3) FS. Law Implemented 456.065(3) FS. History--New 8-15-95, Formerly 59DD-3.014, Repealed.*

**64B24-3.015 Change of Status Fee.**

The fee for processing a licensee's request to change licensure status at any time shall be \$75.

*Rulemaking Authority 456.036 FS. Law Implemented 456.036 FS. History--New 8-15-95, Formerly 59DD-3.015, Amended 9-10-02, Repealed.*

**64B24-3.016 Inactive Renewal Fee.**

The inactive renewal fee is \$500.

*Rulemaking Authority 456.036(3) FS. Law Implemented 456.036 FS. History--New 8-15-95, Formerly 59DD-3.016, Amended 12-23-97, 11-10-99, Repealed.*

**64B24-3.017 Retired Status Fee.**

The retired status fee shall be \$50.00.

*Rulemaking Authority 456.036(15), 467.005 FS. Law Implemented 456.036(4) FS. History--New 5-4-06, Repealed.*

**FLORIDA DEPARTMENT OF HEALTH  
Council of Licensed Midwifery**

**ANNUAL REPORT OF MIDWIFERY PRACTICE**

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

**SECTION I: PRACTICE INFORMATION**

Midwife Name: \_\_\_\_\_ License #: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)**

Section number		Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____
	F	Number of unplanned: Breech: _____ Twins / Multiples _____
	G	Number of planned VBAC: _____ # of primary VBAC: _____ # of subsequent VBAC: _____
	H	Number of water births: _____
	I	Number of mothers requiring sutures: _____
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within 7 days of life)
	C	Number of maternal deaths: (please submit separate report)

**SECTION III. TRANSFER INFORMATION**

**(3-A) ANTEPARTUM TRANSFER (Medical Reasons):** List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
<b>Total Number of Antepartum Transfers from all sheet (3-A)</b>				

**(3-B) INTRAPARTUM TRANSFERS:** List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
<b>Total Intrapartum Transfers from all sheets (3-B)</b>						

**(3-C) MATERNAL POSTPARTUM TRANSFERS:** (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
<b>Total Number of Postpartum Transfers from all sheets (3-C)</b>			

**(3-D) NEWBORN TRANSFERS:** (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
<b>Total Newborn Transfers from all sheets(3-D)</b>					

**SECTION IV - DEATHS**

**(4-A) STILLBIRTH** (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
<b>Total Number of Fetal Death/Stillborn (4-A)</b>						

**(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)**

Date	Cause of Death	Site of Death	Birth Weight	Age at death
<b>Total Number of Fetal/Neonatal Deaths (4-B)</b>				

**(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)**

Number of Reports Attached	
<b>Total Number of Maternal Deaths (4-C)</b>	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_