Application for Temporary Midwifery Certificate in Areas of Critical Need

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

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

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

DH-MQA 5013, Revised 4/2022, Rule 64B24-2.005, F.A.C.

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Do Not Write in this Space
For Revenue Receipting Only

Submit the "Application for Midwifery License by Examination" or "Application for Midwifery License by Endorsement" prior to submitting this application.

Temporary Midwifery Certificate (3202) **$50.00**

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw must be made in writing.

Total fee includes the following:

Application Fee (non-refundable) $50.00

File Number (if known): _______________

1. PERSONAL INFORMATION

Name: ____ **Date of Birth:** ______________
Last/Surname First Middle MM/DD/YYYY

Telephone: ______________________________

2. SUPERVISOR INFORMATION

The supervising practitioner must be an Osteopathic Physician (DO), Allopathic Physician (MD), Certified Nurse Midwife (CNM), or Licensed Midwife (LM).

Name: ____ **License #:** ______________
Last/Surname First Middle (DO, MD, CNM, LM)

Supervisor Telephone: ______________________________

3. AREA OF CRITICAL NEED

Provide the following information about the area of critical need in which you will be practicing.

I am working in a facility. Facility Name: ____

________________________________ ________ ______________________
Facility Address Suite No. City

________________________ ______ ______________ HPSA ID: ______________
State ZIP County (If known)

I am working in a geographic region or am serving a specific population (explain): ______________________

____

I have carefully read the questions in the foregoing application and have answered them completely and without reservation.

Signature ____ Date ______________
MM/DD/YYYY