Application for Midwifery Program Approval

Florida HEALTH
Medical Quality Assurance

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 5076, Revised 4/2022, Rule 64B24-4.002, F.A.C.

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

☐ **Provisional Approval of Midwifery Program (3204 – 1010)**
Select this option if the program is not yet fully accredited and is seeking accreditation, or if the program is already in a pre-accredited status.

☐ **Full Approval of Midwifery Program (3204 – 1020)**
Select this option if the program is fully accredited.

☐ **Full Approval of Current Provisional Midwifery Program (3204 – 1030)**
*Select this option if the program has become fully accredited and is **already** a provisionally approved midwifery program in Florida.*

1. PROGRAM INFORMATION

Program Name: _____

Program Mailing Address/Contact Information:

_____ _____ _____
Street/P.O. Box Suite No. City

_____ _____ _____ _____
State ZIP Country Telephone Number

Program (Physical) Location:

_____ _____ _____
Street Suite No. City

_____ _____ _____
State ZIP Country

Web Address (if applicable): _____

Program Type:	☐ public school in Florida	☐ private, postsecondary school in Florida

Program Confers:	☐ a diploma	☐ an AA or AS degree	☐ an OAS Degree	☐ Other (specify): _____

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

☐ Yes ☐ No Email Address: _____

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

Program Name: _____

2. PROGRAM DIRECTOR INFORMATION

Director Name:		
Director Mailing Address/Contact Information		
Street/P.O. Box:		Suite No.:
City:	State:	ZIP:
Country:	Telephone Number:	

3. SCHOOL LICENSING STATUS

Select one of the following:	
☐	**This school is within the public school system** in the state of Florida.
☐	**This school is a private, postsecondary school in Florida and is not yet licensed** by the Florida Commission for Independent Education.
☐	**This school is a private, postsecondary school in Florida and is provisionally or annually licensed** by the Florida Commission for Independent Education (CIE). CIE License Number: _____

All private, postsecondary schools in Florida are required to be licensed by the Commission for Independent Education. Council staff will attempt to verify the school's license with the Florida Commission for Independent Education.

If the school's licensing status with the Florida Commission for Independent Education cannot be verified or the school is not licensed at the time of application submission, one of the following documents must be submitted:

☐ **A copy of the Order** granting provisional or annual licensing status.

☐ **A copy of the school's Provisional or Annual license.**

Proof of licensure with the Commission for Independent Education may be submitted with this form. After submission of this application, this documentation may be submitted by:

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

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

4. SCHOOL ACCREDITATION STATUS

Select one of the following:	
☐	**This program is accredited** by the Midwifery Education Accreditation Council. Date of Accreditation (MM/DD/YYYY): _____
☐	**This program is in pre-accreditation status** with the Midwifery Education Accreditation Council. Date of Pre-accreditation (MM/DD/YYYY): _____
☐	**This program has applied for pre-accreditation or accreditation status** with the Midwifery Education Accreditation Council. Date of Application (MM/DD/YYYY): _____
☐	**This program is accredited by another entity** or agency (specify): _____
☐	**This program is not accredited and is not seeking pre-accreditation or accreditation status** with any entity or agency.

☐ **All approved midwifery programs in Florida are required to be accredited or pre-accredited, pursuant to section (s.) 467.205, Florida Statutes.** Council staff will attempt to verify that the program is accredited with the Midwifery Education Accreditation Council or other agency specified above.

If the accreditation status cannot be verified or the program is not accredited at the time of application submission, proof of accreditation or pre-accreditation status must be submitted, once attained.

Proof of accreditation or pre-accreditation status may be submitted with this form.
After submission of this application, this documentation may be submitted by:

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

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Tallahassee, FL 32399-3255

Program Name: _____

5. REQUIRED FACULTY

All approved midwifery programs are required to have, as a part of their faculty, a midwife licensed under chapter (ch.) 467, Florida Statutes, and either a Certified Nurse Midwife (CNM) licensed under ch. 464, Florida Statutes, or a physician licensed under ch. 458 or 459, Florida Statutes, who has actively practiced obstetrics within the last four years.

Licensed Midwife Name:
License Number:

Additional Required Faculty Name:		
License Type (select one):	☐	Certified Nurse Midwife (APRN/CNM)
	☐	Allopathic Physician (MD)
	☐	Osteopathic Physician (DO)
License Number:		

6. FACULTY PRECEPTORS

List each member of faculty that will serve as a preceptor as defined in s. 467.003(12), Florida Statutes:

Licensee Name	License Type (select one)	License Number
	☐ APRN/CNM ☐ MD ☐ DO	
	☐ APRN/CNM ☐ MD ☐ DO	
	☐ APRN/CNM ☐ MD ☐ DO	
	☐ APRN/CNM ☐ MD ☐ DO	

7. ADDITIONAL FACULTY / STAFF

List any additional faculty, their title, and license number (if applicable):

Faculty/Staff Name	Title	License Number (if applicable)

8. DOCUMENTATION OF REQUIRED MINIMUM EDUCATION AND CLINICAL TRAINING

Midwifery programs must meet the education and training requirements of s. 467.009, Florida Statutes, and Rules 64B24-4.006, Florida Administrative Code (F.A.C.), regarding minimum education standards, 64B24-4.007, F.A.C., regarding minimum clinical training standards, and 64B24-4.008, F.A.C., regarding administration of the approved midwifery program and recordkeeping.

Course of Study (Direct Entry) - Required Documentation

Submit the following documentation for the course of study:

- ☐ **A course catalog** which includes admission requirements for prospective students, pursuant to Rule 64B24-4.008(2), F.A.C.
- ☐ **Course descriptions** for all courses within the course of study, which demonstrate that the course of study meets minimum education and clinical training standards.
- ☐ **A sample transcript** which complies with Rule 64B24-4.008, F.A.C.

Prelicensure Course

Select one of the following:	
☐	This program **will** offer a prelicensure course.
☐	This program **will not** offer a prelicensure course.

If you selected "this program will offer a prelicensure course," submit the following documentation:

- ☐ **A course catalog** which includes admission requirements for prospective students of the prelicensure course, pursuant to Rule 64B24-4.008(2), F.A.C. *This requirement may be met by a single course catalog submission, if both the course of study and prelicensure course are documented.*
- ☐ **Course descriptions** for all courses within the prelicensure course, which demonstrate that the prelicensure course meets minimum education and clinical training standards.
- ☐ **A sample transcript** for the prelicensure course which complies with Rule 64B24-4.008, F.A.C.

All documentation required in this section may be submitted with your application.
After submission of this application, the required documentation may be submitted by:

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

I, the undersigned, state that I am a person authorized to submit this application on behalf of the program named herein for approval in the state of Florida.

I recognize that providing false information may result in disciplinary action or denial of this application.

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

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

Applicant Signature _____ Date _____

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