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

EMERGENCY BACK UP PLAN FOR LICENSED MIDWIFERY PATIENTS

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

❑ Homebirth ❑ Birth Center ❑ Hospital

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

Midwife's Name: _____

Address: _____

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

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

Address: _____

EMERGENCY TRANSFER HOSPITAL:

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

1. Hospital: _____ E. R. #: ( ) _____-_____ L&D #: _____-_____
   Address: _____ ❑NICU ❑ Perinatal Unit
2. Hospital: _____ E. R. #: ( ) _____-_____ L&D #: _____-_____
   Address: _____ ❑NICU ❑ Perinatal Unit

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

_____

_____

_____

_____

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

❑ City _____ ❑ County _____

BACKUP PHYSICIAN ARRANGEMENT: (if any)

Physician Name: _____ Phone: ( ) _____ -_____

Address: _____

AFFIRMATION:

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

Midwife's Signature: _____ Date: _____