

# 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](http://www.floridahealth.gov/licensing-and-regulation/midwifery)**

**Email: [mqa.midwifery@flhealth.gov](mailto:mqa.midwifery@flhealth.gov)**

**Phone: (850) 245-4161**

**Fax: (850) 412-2681**

**DH-MQA 5013, Revision 7/2020, Rule 64B24-2.004, F.A.C.**



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Do Not Write in this Space  
For Revenue Receiving Only

Submit your "Application for Midwifery Licensure 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 (Input without dashes) \_\_\_\_\_

### 2. SUPERVISOR INFORMATION- 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 Contact Telephone : \_\_\_\_\_  
(Input without dashes)

### 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 \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_ HPSA ID: \_\_\_\_\_  
(If known)

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

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

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*You may print this application and sign it or sign it digitally.* MM/DD/YYYY