Florida Department of Health
Council of Licensed Midwifery
Application for Midwifery Licensure

Apply for your license online at www.flhealthsource.gov

GENERAL INFORMATION

For a detailed list of licensure requirements and information about the licensure process please visit www.floridahealth.gov/licensing-and-regulation/midwifery/index.html.

Fees: All fees must be paid in the form of one cashier's check or money order, made payable to the Department of Health. The fees required for initial licensure are listed below.

Licensure by Examination= $705.00	**Licensure by Endorsement= $955.00**
Application Fee $200.00 (non-refundable)	Application Fee $200.00 (non-refundable)
Licensure Fee $500.00	Endorsement Fee $250.00
Unlicensed Activity Fee $5.00	Licensure Fee $500.00
	Unlicensed Activity Fee $5.00

Military Veterans Fee Waiver: If you are a military veteran, you may be eligible for a waiver of the initial application and licensure fees for all health care professions. Your application must be submitted within 60 months after your honorable discharge from any branch of the United States Armed Forces. You must submit the Military Fee Waiver Form http://www.floridahealth.gov/licensing-and-regulation/armed-forces/_documents/military-veteran-fee-waiver-form.pdf and a copy of your DD-214 or NGB-22 along with the completed licensure application.

Mailing Information: Submit your application, fees, and any supplemental documentation you are sending with your application to the following address:

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

Mail additional information, **not included with your application**, to the following address:

Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

ADDITIONAL DOCUMENTATION REQUIRED FOR EVERY APPLICANT

- ❑ **General Emergency Care Plan:** You must attach a sample general emergency care plan that meets the criteria of Section 467.017(1), FS. At a minimum, the plan should address your strategy for the following once licensed: consultation with other healthcare providers, emergency transfer protocols, and information on access to neonatal intensive care units and obstetrical units.
- ❑ **Exam Scores:** Official documentation mailed directly from North American Registry of Midwives' (NARM) certifying a passing exam score.
- ❑ **HIV/AIDS Course**: Proof of completion of a one hour course on HIV/Aids is required prior to licensure unless you submit an affidavit showing good cause as to why the course has not been completed. Upon receipt of the good cause affidavit you will be given six months from the license date to complete the course and submit proof to the Department.
- ❑ **Additional Documents:** May be required based on answers to application questions and your particular situation. Those items are listed on the application form with the corresponding questions.

Applicants for Licensure by Examination (completion of a Florida approved midwifery program) must also submit:

- ❑ Official transcript mailed directly from the school to the Council office.

Applicants for Licensure by Endorsement (another state license) must also submit:

- ❑ Official verification of all certificates or licenses to practice midwifery in another state, submitted to our office directly from the issuing state. At least one license or certificate must be current, valid and unrestricted.
- ❑ Copy of the other state's laws and rules under which the certificate or license was issued.
- ❑ Official certificate or diploma from a midwifery program approved by the certifying body of the state in which it was located or an authenticated copy of that certificate or diploma.
- ❑ Official transcript from the midwifery program which documents classroom instruction and clinical training.
- ❑ Proof of educational equivalency, which can be determined through the use of an approved education credentialing agency. The following agencies are currently approved by the Council: International Credentialing Associates, Inc. and Josef Silny and Associates, Inc. Please refer to Rule 64B24-2.004(2)(c), F.A.C.
- ❑ Evidence of successful completion of an approved 4-month pre-licensure midwifery training program (please refer to Rule 64B24-2.001(2)(e), F.A.C.).

Applicants for Licensure by Endorsement (foreign trained) must also submit:

- ❑ Valid certificate or diploma from either a foreign institution of medicine or a foreign school of midwifery.
- ❑ Certified translation of the certificate or diploma earned from a foreign institution of medicine or foreign school of midwifery.
- ❑ Proof of educational equivalency, which can be determined through the use of an approved education credentialing agency. The following agencies are currently approved by the Council: International Credentialing Associates, Inc. and Josef Silny and Associates, Inc. Please refer to Rule 64B24-2.004(1)(b), F.A.C.
- ❑ Document which renders the foreign trained applicant eligible to practice medicine or midwifery in the country in which that document was issued.
- ❑ 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.
- ❑ Clarification of the existence of any deviation as to how the applicant's name appears on the face of documents in support of this application.
- ❑ Evidence of successful completion of an approved 4-month pre-licensure midwifery training program (please refer to Rule 64B24-2.001(2)(e), F.A.C.).

COUNCIL OF LICENSED MIDWIFERY
APPLICATION FOR LICENSURE
Mail competed application and fee to:

Department of Health
Council of Licensed Midwifery
Post Office Box 6330
Tallahassee, Florida 32314-6330

Application Method - Check only one
[ ] Licensure by Examination **($705.00)**
[ ] Licensure by Endorsement- Another State License **($955.00)**
[ ] Licensure by Endorsement- Foreign Trained **($955.00)**

☐ **Military Veterans Fee Waiver**: If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee.

PERSONAL INFORMATION:

Name: _____ **Birth Date:** _____
(last) (first) (middle) (mm/dd/yyyy)

List any other names you have been known by: _____

Mailing Address: (the address where mail and your license should be sent)

_____
Street and number or PO Box Suite/Apt #

_____
City State/Province Zip/Postal Code Country

Physical Address: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. If you do not have a current practice address, your mailing address will be used. When you obtain a practice address you will be required to update your online practitioner profile.

_____
Street and number or PO Box Suite/Apt #

_____
City State/Province Zip/Postal Code Country

Telephone: _____ _____ _____
Primary Alternate Cell

Email Address: _____
Under Florida law, email addresses are public records. If you do not want your e-mail 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.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43C FR 38295 August 25, 1978. This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Race: White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other [ ]
Sex: Male [ ] Female [ ]

YES [ ] NO [ ] **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

EDUCATION / TRAINING:

Midwifery Education: List your midwifery school and dates of attendance below.

Midwifery School Name	Address	Attendance Dates (Month/Year)	
		Start	End

Medical Education: List your medical school and dates of attendance below (foreign trained applicants).

Medical School Name	Address	Attendance Dates (Month/Year)	
		Start	End

HIV/AIDS Course: Visit www.CEBroker.com for a list of providers offering this course.

☐ I hereby state that I have completed a minimum one (1) hour course on HIV/AIDs in accordance with s. 381.0034(3), Florida Statutes.

☐ I hereby state that I have not completed a minimum one (1) hour course on HIV/AIDs in accordance with s. 381.0034(3), Florida Statutes. I am submitting a good cause affidavit as to why I have not completed the course. I also acknowledge that proof of the course will be submitted within six months of my license date.

LICENSURE HISTORY:

☐ Yes ☐ No Do you hold or have you ever held a license to practice midwifery or any other profession in any US State or territory, or foreign country? If yes, list below.

State or Country	License Number	Original Issue Date	Method of Licensure (examination, endorsement, grandfathered, etc.)	License Type

DISCIPLINARY HISTORY:

☐ Yes ☐ No Have you had <u>any</u> application for a license to practice any profession, including midwifery, denied by any state board or the licensing authority of any state territory or country?

☐ Yes ☐ No Have you ever had <u>any</u> professional license or license to practice midwifery revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

☐ Yes ☐ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 467.203, Florida Statutes?

☐ Yes ☐ No Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge of violation of the midwifery and/or medical practice act(s), for unprofessional or unethical conduct?

- *A "yes" answer to any of the four questions above requires the following:*
  - *A self explanation on a separate sheet providing accurate details; and*
  - *A copy of the administrative complaint/charging document, final order/document outlining sanctions, and proof of compliance with sanctions (if applicable.)*

☐ Yes ☐ No Have you ever had any judgments entered against you related to the practice of midwifery or any other health care profession?

☐ Yes ☐ No Have you ever been sued for malpractice?

- *A "yes" answer to either of the above two questions requires the following:*
  - *A self explanation listing your involvement in each case.*
  - *A copy of the complaint and disposition for each case.*

CRIMINAL HISTORY:

☐ Yes ☐ No Have you ever been convicted of, or entered a plea of guilty, nolo contendre, or no contest to a crime in any jurisdiction other than a minor traffic offense? ***You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is <u>not</u> considered a minor traffic offense for purposes of this question.***

☐ Yes ☐ No Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances?

- *A "yes" answer to the above two questions requires the following:*
  - *A self explanation listing accurate details (including dates, city/state, charges and final results)*
  - *Final disposition and arrest records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.*
  - *Completion of sentence documents. If unavailable with the Clerk of Courts, obtain from the Department of Corrections. The report must include the start date, end date and that the conditions were met.*

ADDITIONAL CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS:
Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.

1. ☐ Yes ☐ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **(If you responded "no", skip to question 2.)**

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).

c. ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).

2. ☐ Yes ☐ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? **(If you responded "no", skip to question 3.)**

a. ☐ Yes ☐ No If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If you responded "no", skip to question 4.)**

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If you responded "no", skip to question 5.)**

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☐ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

A "yes" answer to any of the above questions requires the following:

- *A self-explanation for each providing accurate details (including the county and state of each termination or conviction, date of each termination or conviction).*
- *Copies of supporting documentation (including court dispositions or agency orders where applicable).*

PROFESSIONAL LIABILITY COVERAGE (Please choose one of the following):

☐ I hereby certify that I have 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.

☐ I hereby certify that I am exempt from demonstrating financial responsibility because I fall into **one of the categories listed below (check one)**:

☐ I practice exclusively as an officer, employee, or agent of the federal government, or of the state of its agencies or subdivisions.

☐ I have an inactive license, and do not practice in the state of Florida.

☐ I practice only in conjunction with my teaching duties at an approved midwifery school.

☐ I do not practice in the state of Florida, but I will submit proof of professional liability coverage at least 15 days prior to practicing midwifery in this state

☐ I have no malpractice exposure in the state of Florida.

I confirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties as provided in Sections 456.067, 456.072, 467.201(5), 467.203(1)(a), 775.082, 775.083, and 775.084, Florida Statutes.

_____ _____

Signature of licensee (required) Date of signature

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE
Council of Licensed Midwifery Application

Name: _____
Last **First** **Middle**

Social Security Number: _____

Social Security Information - * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at **www.ssa.gov** or by calling 1-800-772-1213..

HEALTH HISTORY:

☐ Yes ☐ No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

☐ Yes ☐ No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice midwifery within the past five years?

☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice midwifery?

☐ Yes ☐ No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice midwifery within the last five years?

- *A "yes" answer to any of the above questions requires the following:*
  - *A self explanation providing accurate details (including, but not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved).*
  - *If you have been under treatment for emotional/mental illness, chemical dependency, etc., you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the Board office, to include: treatment received, medications, and dates of treatment and, if applicable, all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).*

STATEMENT OF APPLICANT

These statements are true and correct and I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to 456.067, 775.083 and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers, (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Department of Health any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Midwifery in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature: _____ Date: _____
(MM/DD/YYYY)