Application for Midwifery License by Endorsement

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

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

Florida HEALTH
Medical Quality Assurance

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Do Not Write in this Space
For Revenue Receipting Only

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

Certified Nurse Midwives (CNM) must apply with the Board of Nursing at https://floridasnursing.gov/.
CNMs should not apply with the Council of Licensed Midwifery.

Select one application method for Midwife (3201) **license:**

☐ **Endorsement- Other State** (1030) **$955.00**

☐ **Endorsement- Trained Outside the U.S.** (1030) **$955.00**

Total fee of $955.00 includes the following:

Application Fee (non-refundable)	$200.00
Initial Licensure Fee (refundable)	$500.00
Endorsement Fee (refundable)	$250.00
Unlicensed Activity Fee (refundable)	$5.00

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 or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

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

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

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

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street (Place of Employment) Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

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.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

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 § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. 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 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.

You may apply for licensure before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Include **all** names which may appear on documents submitted in support of your application. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice midwifery or any other health-related license(s)?
☐ Yes ☐ No

C. List all health-related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

All applicants must:

☐ **Submit a License Verification** form to **ALL** states, jurisdictions, and territories where you hold a license or have held a license. License verifications must be received directly from the licensing authority regardless of the status of the license.

Other State License applicants must:

☐ **Hold** at least one current, valid, and unrestricted license or certificate.

☐ **Submit copies** of the laws and rules under which the certificate or license was issued to the council office.

Other State applicants who <u>have not been issued a state license or certificate</u> to practice midwifery:

☐ **Provide a valid certificate or diploma from a midwifery program in another state** which renders the applicant **eligible to practice** midwifery in the state in which that document was issued. **The certificate or diploma must bear the seal of the institution or be otherwise authenticated.**

Applicants Trained Outside the U.S. must:

☐ **Provide a valid certificate or diploma from a foreign institution of medicine or midwifery** which renders the non-U.S. trained applicant **eligible to practice** medicine or midwifery in the country in which that document was issued. **The certificate or diploma must bear the seal of the institution or be otherwise authenticated. Documents that are not in English must have a certified translation.**

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

Name: _____

5. EDUCATION/TRAINING HISTORY

A. **Four-month Prelicensure Course:**

List the Florida approved midwifery program for the four-month pre-licensure course attended.

School Name	Date of Completion (MM/DD/YYYY)

☐ **All applicants must request that their official four-month prelicensure course transcript be sent directly to the council office from their approved midwifery program. Student copies are not acceptable.**

B. **Math and English Competency:**

I attest that:	
☐	**I have a high school diploma** (or equivalent)

I attest that (select all that apply):	
☐	**I have taken and passed three college level credits each of math and English**
☐	**I have passed the College-Level Academic Skills Test** (CLAST)
☐	**I can demonstrate competencies in communication and computation** by passing the College-Level Examination program (CLEP) test in communication and computation

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

☐ I attest that **I have completed** a minimum one-hour course on HIV/AIDS in accordance with s. 381.0034(3), F.S.

☐ I attest that **I have not completed** a minimum one-hour course on HIV/AIDS in accordance with s. 381.0034(3). F.S.

D. **Midwifery Education:** List the midwifery school you attended.

School Name	Graduation Date (MM/DD/YYYY)

Applicants Trained Outside the U.S.- Medical Education: List the medical school you attended.

School Name	Graduation Date (MM/DD/YYYY)

All applicants are required to submit:

☐ **Documentation of substantial educational equivalency** from an approved education credentialing service, per Rules 64B24-2.004(1)(b)2. and 64B24-2.004(2)(c), F.A.C.

The council office will not consider education documents which have not been evaluated by an education credentialing service.

☐ **All applicants educated in the United States** must have an official transcript sent directly to the council office from their school. Student copies are not acceptable. Transcripts should be sent to:

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

Name: _____

6. EXAM HISTORY

North American Registry of Midwives (NARM) Exam Scores- All applicants must request that their scores NARM be sent from directly to the council office. Score reports submitted by applicants will not be accepted. For additional information visit narm.org.

If you have not been authorized to take the NARM examination, you will need authorization to test. Contact your four-month prelicensure program to request that appropriate documentation be sent to the council office.

☐ I have not yet taken the required NARM exam.

☐ I have taken the required NARM exam on _____.
MM/DD/YYYY

7. GENERAL EMERGENCY CARE PLAN

All applicants are required to provide a general emergency care plan that meets the criteria of s. 467.017(1), F.S. Provide the following:

Procedure for Consultation with other health care providers:
Emergency transfer protocols:
Information on access to neonatal intensive care units and obstetrical units:
Additional Information:

This information is exempt from public records disclosure.

8. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

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

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

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status

Name: _____

9. DISCIPLINE HISTORY

A. Have you ever had any professional license or license to practice revoked, suspended, placed on probation, or received a disciplinary action taken in any state, territory, or jurisdiction? ☐ Yes ☐ No

B. Have you ever had any application for a license to practice a profession, including midwifery, denied by any state board/council or the licensing authority of any state, territory, or jurisdiction? ☐ Yes ☐ No

C. Are you currently under investigation or is any disciplinary action pending against you in any state, territory, or jurisdiction that would constitute a violation of s. 467.203, F.S.? ☐ Yes ☐ No

D. Have you ever been notified to appear before any licensing agency for a hearing on a compliant 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? ☐ Yes ☐ No

If you responded "Yes" in questions A-D, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" in questions A-D, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

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

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

If you responded "Yes" in questions E-F, you must provide the following:

☐ **A written self-explanation**, describing in detail your involvement in each case.

☐ A copy of the **Complaint** and **Disposition** for each case.

Name: _____

10. CRIMINAL HISTORY

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

B. 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? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

11. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

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

If you responded "No" to the question above, skip to question 2.

   a. 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? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

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

   d. 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," provide supporting documentation)? ☐ Yes ☐ No

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

If you responded "No" to the question above, skip to question 3.

   a. 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? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

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

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

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

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

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

a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** includes court dispositions or agency orders where applicable.

Documents in sections 8, 9, 10, and 11 must be mailed to:

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

12. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, F.S.

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 granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), F.S., 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

This form is required for ALL applicants.

Council of Licensed Midwifery
Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions.
Choose only ONE option that best describes your situation, unless you choose **option 2** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and will maintain professional liability coverage in an amount of not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer.

☐ 2. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category below.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILTY COVERAGE

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

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

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

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

☐ 5. 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 s. 456.067, 456.072, 467.201(5), 467.203(1)(a), 775.082, 775.083, and 775.084, F.S.

Applicant Signature _____ Date _____
MM/DD/YYYY

Complete verifications must be sent directly from the licensing agency to the council office at:

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

Council of Licensed Midwifery License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Council of Licensed Midwifery.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board/council seal
* Signature and title of state board/council official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination or reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.