Washington State Department of HEALTH

Midwifery License Application Packet

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Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Midwifery Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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Washington State Department of HEALTH

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in ink. It is your responsibility to submit the correct forms required.

Select one: Graduate from a education program that meets the Midwifery Education Accreditation Council (MEAC) standards.
Graduate from an International School
Certified Professional Midwife (CPM)
Certified Professional Midwife (CPM) Trainee

☐ **Application Fee**. This fee is non-refundable. You can check the fee page for current fees.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.
National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name, first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day and year of your birth.

Address: List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county and country. This will be your permanent address with Department of Health until we have been notified of a change. See WAC 246-12-310.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have one.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See WAC 246-12-300.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Education and Training:**
List in date order your educational preparation and post-graduate training. Attach additional pages if you need more space.

☐ **4. Experience:**
List in date order all of your professional experience and practice from date of graduation from professional college. Attach additional pages if you need more space.

☐ **5. Examination Information:**
If you have taken and passed the North American Registry of Midwives (NARM) examination you must have verification from the examination company sent directly to the Department of Health.

☐ **6. Inactive Practice:**
Complete this section if you have not been in the active practice of midwifery prior to initial licensure for three or more years.

☐ **7. Other License, Certification, or Registration:**
List all states where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

☐ **8. Applicant's Attestation:**
You must sign and date this for us to process the application.

Washington State Department of HEALTH

License Requirements

If you graduated from a education program that meets the Midwifery Education Accreditation Council (MEAC) standards you must submit the following:

- ☐ The completed application and fee.
- ☐ Washington State Midwifery Jurisprudence Examination.
- ☐ If you hold a health care license in any state, your health care license certification must be submitted directly from each state. Form enclosed.
- ☐ Transcripts sent directly from your school that shows you have received a Midwifery Certificate or degree and course curriculum. This includes verification of all classroom subjects and clinical training.
- ☐ Verification of successfully passing the national examination offered by the North American Registry of Midwives (NARM)
- ☐ Documentation of attendance at 100 births as required in WAC 246-834-140.

If you have attended an international school you must submit the following:

- ☐ The completed application and fee.
- ☐ Washington State Midwifery Jurisprudence Examination
- ☐ If you hold a health care license in any state, your health care license certification must be submitted directly from each state. Form enclosed.
- ☐ Documentation sent directly from the midwifery school which shows course curriculum. If the transcripts are in a foreign language, they must be transcribed.
- ☐ International applicants licensed outside of USA must have documentation sent directly from the country the midwifery certificate was obtained.
- ☐ Course content form for required midwifery courses. This should be submitted directly from your midwifery program. Form enclosed.
    - Additional documentation may be requested, as needed, to verify that all required course content and/or clinical requirements have been met.
- ☐ Verification of successfully passing the national examination offered by the North American Registry of Midwives (NARM)
- ☐ Documentation of attendance at 100 births as required in WAC 246-834-065.

If you have a current Certified Professional Midwife (CPM) and are applying by CPM you must submit the following as required in WAC 246-834-066.

- [ ] The completed application and fee.
- [ ] Proof of current CPM certification sent directly to the department.
- [ ] Washington State Midwifery Jurisprudence Examination
- [ ] Documentation of attendance at 100 births as required in WAC 246-834-066.*
- [ ] Proof of prenatal and postpartum care examinations WAC 246-834-066.*
- [ ] A signed legend drugs and devices form. Form enclosed. *
- [ ] Successful completion of courses on epidemiology and obstetric pharmacology.*
- [ ] Verification of successfully passing the national examination offered by the North American Registry of Midwives (NARM).
- [ ] If you hold a health care license in any state, your health care license certification must be submitted directly from each state. Form enclosed.

* If you have not met these requirements you may qualify for a CPM trainee permit to complete the requirements listed in WAC 246-834-066.

If you are applying for a CPM trainee permit you must submit the following:

- [ ] The completed application and fee.
- [ ] Proof of current CPM certification sent directly to the department.
- [ ] Verification of successfully passing the national examination offered by the North American Registry of Midwives (NARM).

Midwifery Examination:

North American Registry of Midwives (NARM)

The Department of Health has adopted the national examination offered by the North American Registry of Midwives (NARM) for state licensure. A Washington State specific examination is also required.

Applicants for the NARM examination must also apply directly to NARM using the NARM Agency Candidate Application Form supplied by the department. The agency candidate form will be mailed to each candidate once the department has determined that the candidate is eligible for license in Washington State. The NARM fee must be sent directly to NARM with the agency candidate Form. This fee is in addition to the fees paid to the Department of Health.

Applicants who successfully pass the NARM examination must ensure that verification is sent directly to the Department of Health from NARM.

Washington State Add-On Examination

All applicants will be required to pass the Washington State Add-On Examination. Once all license requirements have been met for full licensure you will be notified of approval to sit for the examination.

Applicants with disabilities who wish to request special accommodations must do so when submitting their application. Form enclosed.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
    - A copy of your marriage certificate to show proof of marriage; or
    - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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Washington State Department of HEALTH

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Midwifery License Application

Select one: ☐ Graduate from an Education Program that meets that MEAC Standards
☐ Graduate from an International School ☐ Certified Professional Midwife (CPM) Trainee
☐ Certified Professional Midwife (CPM)

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer not to answer ☐ X

Name	First	Middle	Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

	Yes	No
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

3. Education and Training

List in date order all of your educational preparation and post-graduate training. If you need more space, attach a sheet of paper.

Attendance		Name and address of institute, or place of practice	Degree Earned
Start mm/yyyy	End mm/yyyy		

4. Experience

List in date order all of your professional experience. If you need more space, attach a sheet of paper.

Attendance		Name and address of institute, place of practice	Type of experience or specialty
Start mm/yyyy	End mm/yyyy		

5. Examination Information

Have you taken and successfully passed the North American Registry of Midwives (NARM) examination?

☐ Yes ☐ No

Are you requesting approval to sit for the North American Registry of Midwives (NARM) examination?

☐ Yes ☐ No

Note: Prior to licensure you must take and pass the North American Registry of Midwives (NARM) examination.

6. Inactive Practice -

Complete this section only if you have not been in active practice within the last three years. This section doesn't apply to those who graduated in the last three years.

A preceptor is a licensed midwife or other obstetric practitioner license by their state or jurisdiction to provide maternity care who assumes responsibly for supervising the practical experience of a student midwife.

Preceptor Name	Preceptor License Number	State of Licensure

If you have not been engaged in the active practice of midwifery for more than **three years but less than five years**, please complete this section.

I certify that I completed a minimum of 10 births while acting as a birthing assistant under the supervision of the above named preceptor within the last 12 months. I am enclosing documentation of proof of these 10 births.

I also certify that I have completed the continuing education requirements for the three years prior to submission of this application as shown in WAC 246-834-355.

Applicant's Initials	Today's Date

If you have not been engaged in the active practice of midwifery for **more than five years**, please complete this section.

I certify that I completed a minimum of 15 births while acting as a birthing assistant under the supervision of the above named preceptor within the last 12 months. I am enclosing documentation of proof of these 15 births.

I also certify that I have completed the continuing education requirements for the three years prior to submission of this application as shown in WAC 246-834-355.

Applicant's Initials	Today's Date

7. Other License, Certification, Registration

List all states where credentials are or were held. List credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. If you need more space, attach a sheet of paper.

State	Profession	License	License Type	Method of License	Currently in force
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes

9. Applicant's Attestation

I,____________________________________, declare under penalty of perjury under the laws of the state
(Print applicant name clearly)
of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated ______________________________ at ____
(mm/dd/yyyyy) (city/state)

By: __________________________________
(Original signature of applicant)

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Midwifery Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Washington State Legend Drugs and Devices Preceptor Sign-Off Form WAC 246-834-250

In order to ensure that Certified Professional Midwife and foreign trained applicants have obtained sufficient education and training in the use of obstetric pharmacological agents and devices, they must obtain their preceptor's signature certifying that the applicant has demonstrated correct usage and administration of the following legend drugs and devices.

Form instructions:

- Please have each preceptor fill out a separate form
- The knowledge component may be verified outside of a clinical setting
- Skills must be demonstrated to, and attested by, the preceptor

Applicant Name:		
Pharmacological Agents	**Knowledge Signature/Date**	**Skill Signature/Date**
Rho (D) immune globulin		
Postpartum oxytocic and antihemorrhagic drugs to control postpartum hemorrhage including, but not limited to, oxytocin, misoprostol, methylergonovine maleate (oral or intramuscular), and prostaglandin F2 alpha		
IV fluids limited to lactated Ringers, 5% dextrose with lactated Ringers, and sodium chloride		
Sterile water for intradermal injections for pain relief		
Local anesthetic medications		
Vitamin K injection		
Newborn prophylactic ophthalmic medication		
Nitrous oxide as an analgesic, self-administered inhalant in a 50 percent blend with oxygen, and associated equipment, including scavenging system		
Terbutaline to temporarily decrease contractions pending emergent intrapartal transport		
Magnesium sulfate for prevention of maternal seizures pending transport		
Antibiotics for intrapartum prophylaxis of Group Beta Hemolytic Streptococcus (GBS) per current CDC guidelines		
Epinephrine for use in maternal anaphylaxis and resuscitation and neonatal resuscitation pending transport		

Vaccines	Knowledge Signature/Date	Skill Signature/Date
Any vaccines recommended by the CDC advisory committee on immunization practices for pregnant or postpartum people or infants in the first two weeks after birth, as it existed on the effective date of **WAC 246-834-250**		
Measles, mumps and rubella (MMR) vaccine to non-immune postpartum women		
Tetanus, diphtheria, acellular pertussis (Tdap) vaccine for use in pregnancy		
Hepatitis B (HBV) birth dose for any newborn administration		
Influenza vaccine for use in pregnancy		
HBIG and HBV (for neonates born to hepatitis B positive mother)		

Devices and Supplies	Knowledge Signature/Date	Skill Signature/Date
Dopplers		
Syringes, needles, phlebotomy equipment		
Sutures		
Urinary Catheters		
Intravenous Equipment		
Amnihooks		
Airway suction devices		
Electronic fetal monitoring, tocodynamometer monitor		
Neonatal and adult resuscitation equipment and medication, including airway devices		
Oxygen and associated equipment		
Glucose monitoring systems and testing strips		

Neonatal pulse oximetry equipment		
Hearing screening equipment		
Centrifuge		
Breast pumps, compression stockings and belts, maternity belts		
Diaphragms and cervical caps		
Iron supplements and prenatal vitamins		

Applicant Signature: ______________________________ Date ____________________

I attest that the applicant has shown the proper knowledge of usage and administration of all signed items on this form.

Preceptor Name: (please print) ______________________________

Address: ______________________________

Phone: ______________________________

Email: ______________________________

Credential Type: ______________________________

Preceptor Signature:

____

Midwifery Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Disability Accommodation Request

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. [Section 504 of the Rehabilitation Act (29 USC 12101)]. Please call 360-236-4700 if you have questions about the types of accommodations available.

Name ______________________________

Address ______________________________

Phone ______________________ Social Security Number ______________________

Accommodations requested for the ______________________ Midwifery examination.

I have the disability ______________________ and request the

following accommodation(s) at the testing site ______________________

____

Name (please print) ______________________________

Signed ______________________ Date ______________________

Documentation of Disability Related Needs

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate licensed health care professional (doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, for example in your midwifery education program, you may submit such documentation instead of having this portion of the form completed.

I have known ____________ since ____________ in my capacity as a ____________
Test applicant mm/yyyy Professional title

The applicant has the disability ______________________________

diagnosed by the following tests or studies ______________________________

I recommend the following accommodation(s) be provided for this individual ______________________

Name (please print) ______________________ Title ______________________

Address ______________________________

____

Telephone ______________________ License Number ______________________

Signed ______________________ Date ______________________

If accommodations for testing were made for the candidate during progression through the Midwifery education program, provide a letter from the director indicating what modifications were made.

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Midwifery Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Required Midwifery Courses

RCW 18.50.040
WAC 246-834-140

This form is for international applicants, out-of-state applicants, and applicants that did not graduate from a Washington State approved school. This form must be submitted directly from your midwifery program to the Department of Health.

Applicant Name____

	Date	Course
1. Obstetrics, normal & abnormal	____________	________________
2. Neonatal Pediatrics/neonatology...........	____________	________________
3. Basic Sciences to include:		
Biology	____________	________________
Microbiology	____________	________________
Anatomy with emphasis on female reproductive anatomy	____________	________________
Physiology	____________	________________
Genetics	____________	________________
Embryology...	____________	________________
Behavioral Sciences	____________	________________
4. Childbirth Education	____________	________________
5. Community Care...................................	____________	________________
6. Obstetrical Care....................................	____________	________________
7. Epidemiology	____________	________________
8. Gynecology, normal & abnormal	____________	________________
9. Family Planning	____________	________________

(Complete both pages of form)

	Date	Course
10. Medical/Legal Aspects of Midwifery........		
11. Nutrition during Pregnancy & Lactation ..		
12. Breast feeding		
13. Nursing skills to include:		
Vital Signs...		
Perineal Prep..		
Catheterization		
Aseptic Techniques...............................		
Administration/Oral Medications............		
Administration/Injections........................		
Local Infiltration of Anesthesia...............		
Venipuncture...		
Administration of Intravenous Fluids		
Infant & Adult Resuscitation...................		
Charting		
14. Obstetrical Pharmacology		

15. Student observed ____________ births before graduation.
Number

16. Student managed ____________ births with a preceptor before graduation.
Number

17. Student cared for ____________ women in the prenatal period before graduation.
Number

18. Student cared for ____________ women in the early postpartum period before graduation.
Number

(Complete both pages of form)

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Midwifery Laws, RCW 18.50

Midwifery Rules, WAC 246-834

Online

Midwifery Advisory Committee, Web Page

North American Registry of Midwives (NARM), http://www.narm.org