

TITLE 9. HEALTH SERVICES EXHIBIT B. MIDWIFE LICENSE APPLICATION FORM  
 DIVISION OF FAMILY HEALTH SERVICES  
 APPLICATION PART I  
 MIDWIFE APPRENTICESHIP DOCUMENTATION  
 GENERAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

2 X 2 PHOTOGRAPH

Phone (home): \_\_\_\_\_

Phone (work): \_\_\_\_\_

Accepted for exam on: \_\_\_\_\_ ENCLOSE FILING FEE OF \$25.00  
 TESTING FEE IS \$100.00

Core Subjects:	Grade:	Study Completed at:
Anatomy & Physiology _____	_____	_____
Embryology/Genetics _____	_____	_____
Pharmacology _____	_____	_____
Psychology _____	_____	_____
Nutrition _____	_____	_____

II. Practical Experience Grade:	General Experience Grade:
Prenatal visits (60) _____	Overall Care _____
Observe birth (10) _____	Recognition & Intervention
L & D Management (25) _____	of norm., abnormal & emerg. _____
Newborn Exams (25) _____	Universal Precautions _____
Postpartum Exam (25) _____	Technique of obtaining spec. _____
Childbirth Prep class ( 6) _____	Techniques of record manage. _____
Physical Assessment Adult & NB _____	

(Refer to attached detail)

III. American Heart Association CPR Certification Exp. Date  
 CPR Adult & Infant (Certified copy of cards enclosed) \_\_\_\_\_

IV. Letters of Recommendation

Three letters of recommendation must be mailed directly to the Program Manager from the following individuals: your preceptor, a physician or certified nurse midwife, and a client.

Have you ever been convicted of a felony? Yes No

Have you ever been convicted of a misdemeanor? Yes No

Explanation: \_\_\_\_\_

By signing this application, I certify under penalty of law that the information provided anywhere in this application is true, correct, and complete to the best of my knowledge and belief. I also acknowledge that, should investigation at any time disclose any misrepresentation or falsification, my license will be revoked, denied, or suspended. I also authorize the Department to make all necessary and appropriate investigations allowable by law to verify the information provided:

\_\_\_\_\_  
 Applicant Date

Social Security # \_\_\_\_\_ E-mail address \_\_\_\_\_

DIVISION OF FAMILY HEALTH SERVICES  
APPLICATION PART II  
VALIDATION OF MIDWIFERY APPRENTICESHIP

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Apprentice time period. Began on: \_\_\_\_\_ Completed on: \_\_\_\_\_

Preceptor Name & Title: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

(Enclose a copy of your current license and circle the expiration date.)

By signing this application, I certify under penalty of law that the information provided anywhere in this application is true, correct, and complete to the best of my knowledge and belief. I also acknowledge that, should investigation at any time disclose any misrepresentation or falsification, my license will be revoked, denied, or suspended. I also authorize the Department to make all necessary and appropriate investigations allowable by law to verify the information provided:

\_\_\_\_\_  
Preceptor's Signature Date

\_\_\_\_\_  
Notary / Expiration Date Date

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1).

**EXHIBIT C. PRECEPTOR RATING GUIDE**

The following assessment form is provided to act as a guide for the preceptor and student. This guide will act as a standard to measure student strengths and opportunities for improvement.

1. Excellent: Demonstrates consistently high level of performance using sound scientific principles for practice, able to motivate patient and family in practice, uses consultation, requires minimal supervision.
2. Above Average: Generally performs with competence but requires periodic supervision, uses consultation appropriately, applies sound scientific principles to practice, protects patient's safety and dignity.
3. Average: Performs procedures adequately but needs supervision, can answer questions relative to underlying scientific principles, practice more self-centered than client-centered.
4. Below Average: Needs considerable supervision, can perform skills if has them demonstrated or reinforced; knows most of the principles underlying procedures but needs help in making application in the situation.
5. Unacceptable: Cannot perform skill with even minimal competence, does not know or understand principles underlying the procedures to be performed, practices inappropriately so as to threaten patient's safety, dignity, or comfort. Unable to judge.

EXHIBIT D. RENEWAL APPLICATION FORM  
ARIZONA DEPARTMENT OF HEALTH SERVICES  
FAMILY HEALTH SERVICES  
WOMEN'S AND CHILDREN'S HEALTH  
APPLICATION FOR BIENNIAL RENEWAL OF MIDWIFE LICENSE

1. NAME: \_\_\_\_\_ 2. MIDWIFE LICENSE NUMBER: \_\_\_\_\_  
Last First Middle

3. SOCIAL SECURITY NUMBER: \_\_\_\_\_ 4. DATE OF BIRTH: \_\_\_\_\_  
(day/month/year)

5. HOME ADDRESS: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Street Address Area Code/Telephone Number

\_\_\_\_\_  
Mailing Address (if different from street address)  
\_\_\_\_\_  
E-Mail address \_\_\_\_\_  
City County State Zip

6. BUSINESS ADDRESS:  
\_\_\_\_\_  
Business Title  
\_\_\_\_\_  
Street Address (\_\_\_\_\_) \_\_\_\_\_  
Area Code/Telephone Number

\_\_\_\_\_  
Mailing Address (if different from street address)  
\_\_\_\_\_  
City County State Zip

7. CONSUMER LISTING:  
A listing of the licensed midwives is maintained for ADHS use. Consumers and various groups request copies of the listing of licensed midwives. Do you wish to have your name on this list? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, which name, address, and phone number would you like to have on that list?  
\_\_\_\_\_  
Name and Business Title  
\_\_\_\_\_  
Street or Post Office Box (\_\_\_\_\_) \_\_\_\_\_  
Area Code/Telephone Number  
\_\_\_\_\_  
City County State Zip

8. ATTENDING DELIVERIES:  
  
1) If you do not plan to attend any births during the next licensure period (July 1 to June 30), please complete the following statement. I do not plan to attend any deliveries as a licensed midwife from July 1, \_\_\_\_ to June 30, \_\_\_\_.  
Signature: \_\_\_\_\_

2) If you do attend births after signing this statement, you must submit quarterly reports.

9. MIDWIFERY PRACTICE:  
  
1) Have you had any maternal deaths during the past licensure period? Yes \_\_\_\_\_ No \_\_\_\_\_.  
If yes, give client name and number.  
\_\_\_\_\_

2) Have you delivered any stillborn infants during the past licensure period?

Yes \_\_\_\_ No \_\_\_\_ . If yes, give client name and number.

3) Have any of the infants you delivered died within the first 28 days of life?

Yes \_\_\_\_ No \_\_\_\_ . If yes, give client name and number.

10. Do you have any communicable diseases (i.e., tuberculosis, rubella, hepatitis, etc.)?

Yes \_\_\_\_ No \_\_\_\_ . If yes, please explain on a separate sheet of paper.

11. Besides your midwifery license, do you hold any other licenses in Arizona as a health care provider (i.e., R.N., E.M.T.,N.D., etc.)?

Yes \_\_\_\_ No \_\_\_\_ . If yes, what other licenses do you hold? \_\_\_\_\_

12. Have you been convicted of a felony or a misdemeanor (besides a traffic ticket) during the past licensure period?

Yes \_\_\_\_ No \_\_\_\_ . If yes, please explain on a separate sheet of paper.

13. What are the backup facilities you expect to use?

Name Address

1) Hospitals: \_\_\_\_\_

2) Physicians: \_\_\_\_\_

3) Other: \_\_\_\_\_

I certify that the above information is true, complete, and correct.

Signature: \_\_\_\_\_ Date of Application \_\_\_\_\_

Attach affidavit of continuing education.

\*\*\*\*\*  
DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

Date Renewal Notice Sent \_\_\_\_\_ Date Renewal Form Returned \_\_\_\_\_

Application returned on \_\_\_\_\_ for \_\_\_\_\_

Date completed application received \_\_\_\_\_ License Renewal Granted: Yes \_\_\_\_ No \_\_\_\_ Other \_\_\_\_\_

Effective Date of License \_\_\_\_\_ Application Reviewed by \_\_\_\_\_

MIDWIFE LICENSING PROGRAM  
AFFIDAVIT OF CONTINUING EDUCATION  
(To be attached to application for biennial renewal of license)

A.A.C. R9-16-105(C) requires a licensed midwife to obtain 10 continuing education units (CEUs) during the term of a license. A CEU is defined by the approving agency.

Units are acceptable for continuing education when approved by one of the following:

- American Nurses Association
- American College of Obstetrics and Gynecologists
- American Medical Association
- Midwives Alliance of North America
- American College of Nurse Midwives

COMPLETE THE FOLLOWING:

NAME:

\_\_\_\_\_

ADDRESS

\_\_\_\_\_

CITY/STATE/ZIP

\_\_\_\_\_

TITLE SPONSOR/AGENCY DATE CITY/STATE CEUs/HOURS

\_\_\_\_\_

I hereby swear or affirm that the information given on this form is accurate and complete, and that I have maintained records as evidence of compliance.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

My commission expires: \_\_\_\_\_

Historical Note  
Adopted effective March 14, 1994 (Supp. 94-1).

