TITLE 9. HEALTH SERVICES

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES - OCCUPATIONAL LICENSING

ARTICLE 1. LICENSING OF MIDWIFERY

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ARTICLE 1. LICENSING OF MIDWIFERY

R9-16-101. Definitions

In addition to the definitions in A.R.S. § 36-751, the following definitions apply in this Article unless otherwise specified:

1. "Amniotic" means the fluid surrounding a fetus while in the mother's uterus.
2. "Apgar score" means the number indicating a newborn's physical condition, attained by rating selected body functions.
3. "Breech" means a complete breech, a frank breech, or an incomplete breech.
4. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
5. "Certified nurse midwife" means an individual who meets the criteria in 4 A.A.C. 19, Article 5, and is certified by the Arizona State Board of Nursing.
6. "Cervix" means the narrow lower end of the uterus that protrudes into the cavity of the vagina.
7. "Client" means a pregnant woman accepted by a midwife for the provision of midwifery services from the midwife.
8. "Complete breech" means that, at the time of birth, the buttocks of a fetus are pointing downward with both legs folded at the knees and the feet near the buttocks.
9. "Consultation" means communication between a midwife and a physician or a midwife and a certified nurse midwife for the purpose of receiving a written or verbal recommendation and implementing prospective advice regarding the care of a pregnant woman or the woman's fetus or newborn.
10. "Dilation" means opening of the cervix during the mechanism of labor to allow for passage of the fetus.
11. "Effacement" means the gradual thinning of the cervix during the mechanism of labor and indicates progress in labor.
12. "Emergency care plan" means the arrangements established by a midwife for a client's transfer of care in a situation in which the health or safety of the client or newborn is determined to be at risk.
13. "Emergency medical services provider" has the same meaning as in A.R.S. § 36-2201.
14. "Episiotomy" means the cutting of the perineum, at the center, middle, or midline, in order to enlarge the vaginal opening for delivery.
15. "Fetus" means a child in utero from conception to birth.
16. "Frank breech" means that, at the time of birth, the buttocks of a fetus are pointing downward with both legs folded flat up against the head.

17. "Gestation" means the length of time from conception to birth, as calculated from the first day of the last normal menstrual period.
18. "Incomplete breech" means that, at the time of birth, the buttocks of a fetus are pointing downward with one leg folded at the knee with the foot near the buttocks.
19. "Informed consent" means a document signed by a client, as provided in R9-16-109, agreeing to the provision of midwifery services.
20. "Jurisprudence test" means an assessment of an individual's knowledge of the:
    a. Laws of this state concerning the reporting of births, prenatal blood tests, and newborn screening; and
    b. Rules pertaining to the practice of midwifery.
21. "Ketones" means certain harmful chemical elements that, when present in the body in excessive amounts, results in compromised bodily function.
22. "Meconium" means the first bowel movement of the newborn, which is greenish black in color and tarry in consistency.
23. "Midwifery services" means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery, or postpartum care.
24. "Newborn" has the same meaning as in A.R.S. § 36-694.
25. "Perineum" means the muscular region in the female between the vaginal opening and the anus.
26. "Physician" means an allopathic, an osteopathic, or a naturopathic practitioner licensed according to A.R.S. Title 32, Chapter 13, 14, or 17.
27. "Postpartum" means the six-week period following delivery of a newborn and placenta.
28. "Prenatal" means the period from conception to the onset of labor and birth.
29. "Prenatal visit" means each clinical examination of a pregnant woman for the purpose of monitoring the course of gestation and the overall health of the woman.
30. "Quickening" means the first perceptible movement of the fetus in the uterus, occurring usually in the 16th to the 20th week of gestation.
31. "Rh" means a blood antigen.
32. "Transfer of care" means that a midwife refers the care of a client or newborn to an emergency medical services provider, a certified nurse midwife, a hospital, or a physician who then assumes responsibility for the direct care of the client or newborn.
33. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday or a statewide furlough day.

R9-16-102. Application for an Initial License

A. An applicant for an initial license to practice midwifery shall submit:

1. An application in a format provided by the Department that contains:
    a. The applicant's name, address, telephone number, and e-mail address;

b. The applicant's Social Security Number, as required under A.R.S. §§ 25-320 and 25-502;
c. Whether the applicant has ever been convicted of a felony or a misdemeanor in this or another state or jurisdiction;
d. If the applicant was convicted of a felony or misdemeanor:
   i. The date of the conviction,
   ii. The state or jurisdiction of the conviction,
   iii. An explanation of the crime of which the applicant was convicted, and
   iv. The disposition of the case;
e. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-107(C)(2);
f. An attestation that information required as part of the application is true and accurate; and
g. The applicant's signature and date of signature;

2. Documentation for the applicant that complies with A.R.S. § 41-1080;
3. Documentation that demonstrates the applicant is 21 years of age or older if the documentation submitted in subsection (A)(2) does not demonstrate that the applicant is 21 years of age or older;
4. Current documentation of completion of training in:
   a. Adult basic cardiopulmonary resuscitation through a course recognized by the American Heart Association, and
   b. Neonatal resuscitation through a course recognized by the American Academy of Pediatrics or American Heart Association;
5. Documentation of a high school diploma, a high school equivalency diploma, an associate degree, or a higher degree;
6. Documentation that the applicant is certified by the North American Registry of Midwives as a Certified Professional Midwife;
7. Except as provided in subsection (B), a non-refundable application fee of $25; and
8. A non-refundable testing fee of $100 for a jurisprudence test administered by the Department.

B. An applicant is not required to submit the fee in subsection (A)(7) or (E)(1) if the applicant, as part of the application in subsection (A), submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.

C. The Department shall review an application for an initial license to practice midwifery according to R9-16-107 and Table 1.1.

D. If an applicant receives notification of eligibility to take the jurisprudence test, the applicant:

1. Shall take the jurisprudence test administered by the Department;
2. Shall provide proof of identity by a government-issued photographic identification card upon the request of the individual administering the jurisprudence test;

3. May take the jurisprudence test as many times as desired, within 180 calendar days after the date of the notification, without paying an additional testing fee; and
4. Shall score 80% or higher correct answers on the jurisprudence test to be eligible to receive an initial license to practice midwifery.

E. If an applicant scores 80% or higher correct answers on the jurisprudence test, the Department shall provide written notice to the applicant, within five working days after the date of the jurisprudence test, to submit to the Department:

1. Except as provided in subsection (B), a licensing fee of $25; and
2. The documentation required in subsection (A)(4) or (6), if the documentation of training required in subsection (A)(4) or certification required in subsection (A)(6) is not current.

F. The Department shall issue an initial license to practice midwifery within five working days after receiving the applicable documentation and licensing fee required in subsection (E).

G. The Department shall provide to an applicant a written notice of denial that complies with A.R.S. § 41-1092.03(A) and inform the applicant that the applicant may reapply under subsection (A) if the applicant does not:

1. Score 80% or higher correct answers on the jurisprudence test within 180 calendar days after the date of the notification of eligibility to take the jurisprudence test, or
2. Submit to the Department the applicable documentation and licensing fee required in subsection (D) within 120 calendar days after the date of the notification in subsection (D).

R9-16-103. License Renewal

A. At least 30 calendar days and no more than 60 calendar days before the expiration date of a midwifery license, a midwife shall submit to the Department:

1. An application for renewal of a midwifery license, in a format provided by the Department, that contains:
   a. The midwife's name, address, telephone number, and e-mail address;
   b. The midwife's license number;
   c. Whether the midwife has been convicted of a felony or a misdemeanor in this or another state or jurisdiction in the previous two years;
   d. If the midwife was convicted of a felony or misdemeanor:
      i. The date of the conviction,
      ii. The state or jurisdiction of the conviction,
      iii. An explanation of the crime of which the midwife was convicted, and
      iv. The disposition of the case;
   e. Whether the midwife agrees to allow the Department to submit supplemental requests for information under R9-16-107(C)(2);
   f. An attestation that the midwife has completed the continuing education requirement in R9-16-105;

g. An attestation that the midwife is complying with the requirements in A.R.S. § 32-3211;
h. An attestation that information required as part of the application is true and accurate; and
i. The midwife's signature and date of signature;

2. Either:
a. Documentation that the midwife is currently certified by the North American Registry of Midwives as a Certified Professional Midwife; or
b. For a midwife who has been continuously licensed as a midwife by the Department since 1999, a copy of both sides of documentation showing the completion of current training in:
i. Adult basic cardiopulmonary resuscitation that meets the requirements in R9-16-102(A)(4)(a), and
ii. Neonatal resuscitation that meets the requirements in R9-16-102(A)(4)(b); and

3. A non-refundable renewal fee of $25.

B. The Department shall review an application for renewal of a license to practice midwifery according to R9-16-107 and Table 1.

R9-16-104. Administration

A. A midwife may submit a written request for the Department to:
1. Add the midwife's name, address, and telephone number to a list of licensed midwives on the Department's website; or
2. Remove the midwife's name, address, and telephone number from a list of licensed midwives on the Department's website.

B. A midwife shall:
1. Notify the Department in a format provided by the Department within five working days after:
a. A client has died while under the midwife's care,
b. A stillborn child has been delivered by the midwife, or
c. A newborn delivered by the midwife has died within the first six weeks after birth; and
2. Provide a summary of the:
a. Circumstances leading up to the event, and
b. Actions taken by the midwife in response to the event.

C. A midwife shall:
1. Maintain documentation of:
a. Completion of current training in:
i. Adult basic cardiopulmonary resuscitation that meets the requirements in R9-16-102(A)(4)(a), and
ii. Neonatal resuscitation that meets the requirements in R9-16-102(A)(4)(b);
b. Except as provided in R9-16-103(A)(2)(b), current certification as a Certified Professional Midwife by the North American Registry of Midwives; and
c. The continuing education required in subsection R9-16-105 for at least the previous three years; and

2. Provide a copy of documentation required in subsection (C)(1) to the Department within two working days after the Department's request.

R9-16-105. Continuing Education

During the term of a midwifery license, the midwife shall obtain at least 20 hours of continuing education that:

1. Improve the midwife's ability to:
   a. Provide services within the midwife's scope of practice,
   b. Recognize and respond to situations outside the midwife's scope of practice, or
   c. Provide guidance to other services a client may need; and
2. Have been approved as applicable to the practice of midwifery by the:
   a. American Nurses Association,
   b. American Congress of Obstetrics and Gynecologists,
   c. Midwives Alliance of North America,
   d. Arizona Medical Association,
   e. American College of Nurse Midwives,
   f. Midwifery Education Accreditation Council, or
   g. Another health professional organization.

R9-16-106. Name Change; Duplicate License

A. To request a name change on a midwifery license or a duplicate midwifery license, a midwife shall submit in writing to the Department:

1. The midwife's name on the current midwifery license;
2. If applicable, the midwife's new name;
3. The midwife's address, license number, and e-mail address;
4. As applicable:
   a. Documentation supporting the midwife's name change, or
   b. A statement that the midwife is requesting a duplicate midwifery license; and
5. A non-refundable fee of $10.00.

B. Upon receipt of the written request required in subsection (A), the Department shall issue, as applicable:

1. An amended midwifery license that incorporates the name change but retains the expiration date of the midwifery license, or
2. A duplicate midwifery license.

R9-16-107. Time-frames

A. The overall time-frame described in A.R.S. § 41-1072(2) for each type of license granted by the Department is specified in Table 1.1. The applicant or midwife and the Department may agree in writing to extend the

substantive review time-frame and the overall time-frame. The substantive review time-frame and the overall time-frame may not be extended by more than 25 percent of the overall time-frame.

B. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for each type of license granted by the Department is specified in Table 1.1.

1. The administrative completeness review time-frame begins:
   a. For an applicant submitting an application for an initial license, when the Department receives the application packet required in R9-16-102(A); and
   b. For a licensed midwife applying to renew a midwifery license, when the Department receives the application packet required in R9-16-103(A).
2. If an application is complete, the Department shall provide to the applicant or midwife, during the administrative completeness review time-frame:
   a. A notice of administrative completeness, or
   b. A notice of eligibility to take the jurisprudence test or a license.
3. If an application is not complete, the Department shall provide a notice of deficiencies to the applicant or midwife describing the missing documentation or incomplete information.
   a. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Department receives the documentation or information listed in the notice of deficiencies.
   b. An applicant or midwife shall submit to the Department the documentation or information listed in the notice of deficiencies in subsection (B)(3) within the time specified in Table 1.1 for responding to a notice of deficiencies.
   c. If the applicant or midwife submits the documentation or information listed in the notice of deficiencies within the time specified in Table 1.1, the Department shall provide a written notice of administrative completeness to the applicant or midwife.
   d. If the applicant or midwife does not submit the documentation or information listed in the notice of deficiencies within the time specified in Table 1.1, the Department shall consider the application withdrawn.

C. The substantive review time-frame described in A.R.S. § 41-1072(3) is specified in Table 1.1 and begins on the date of the notice of administrative completeness.

1. If an application complies with the requirements in this Article and A.R.S. Title 36, Chapter 6, Article 7, the Department shall issue a notice of eligibility to take the jurisprudence test to an applicant or a license to a midwife.
2. If an application does not comply with the requirements in this Article or A.R.S. Title 36, Chapter 6, Article 7, the Department shall make one comprehensive written request for additional information, unless the

applicant or midwife has agreed in writing to allow the Department to submit supplemental requests for information.

a. The substantive review time-frame and the overall time-frame are suspended from the date that the Department sends a comprehensive written request for additional information or a supplemental request for information until the date that the Department receives all of the information requested.

b. An applicant or midwife shall submit to the Department all of the information requested in a comprehensive written request for additional information or a supplemental request for information in subsection (C)(2) within the time specified in Table 1.1.

c. If the applicant or midwife does not submit the additional information within the time specified in Table 1.1 or the additional information submitted by the applicant or midwife does not demonstrate compliance with this Article and A.R.S. Title 36, Chapter 6, Article 7, the Department shall provide to the applicant a written notice of denial that complies with A.R.S. § 41-1092.03(A).

d. If the applicant or midwife submits the additional information within the time specified in Table 1.1 and the additional information submitted by the applicant or midwife demonstrates compliance with this Article and A.R.S. Title 36, Chapter 6, Article 7, the Department shall issue a notice of eligibility to take the jurisprudence test to an applicant or a license to a midwife.

Table 1.1. Time-frames (in calendar days)

Type of Approval	Statutory Authority	Overall Time-Frame	Administrative Completeness Review Time-Frame	Time to Respond to Notice of Deficiency	Substantive Review Time-Frame	Time to Respond to Comprehensive Written Request
Eligibility for Jurisprudence Test (R9-16-102)	A.R.S. §§ 36-753, 36-754, and 36-755	30	15	60	15	30
Midwifery License Renewal (R9-16-103)	A.R.S. § 36-754	30	15	30	15	15

R9-16-108. Responsibilities of a Midwife; Scope of Practice

A. A midwife shall provide midwifery services only to a woman:

1. Who does not have any of the conditions specified in R9-16-111(B) through (E) or another condition that may increase the risk of harm to the woman or the woman's fetus or newborn during pregnancy or labor,

as determined through a physical assessment and review of the woman's medical history and past pregnancies; and

2. Whose expected outcome of pregnancy is most likely to be the delivery of a newborn, with none of the conditions requiring transfer of care as specified in R9-16-111(J)(1), and an intact placenta.

B. Except as provided in R9-16-111(C) or (D), a midwife who is certified by the North American Registry of Midwives as a Certified Professional Midwife may accept a client for a vaginal delivery:

1. After prior Cesarean section, or
2. Of a fetus in a complete breech or frank breech presentation.

C. Before providing services to a pregnant woman, a midwife shall:

1. Inform the pregnant woman, both orally and in writing, of:
   a. The midwife's scope of practice, educational background, and credentials, as specified in R9-16-102(A)(4) and (6) as applicable;
   b. If applicable to the pregnant woman's condition, the midwife's experience with:
      i. Vaginal birth after prior Cesarean section delivery, or
      ii. Delivery of a fetus in a complete breech or frank breech presentation;
   c. The potential risks; adverse outcomes; neonatal or maternal complications, including death; and alternatives associated with an at-home delivery specific to the pregnant woman's condition, including the conditions described in subsection (C)(1)(b);
   d. The requirement for tests specified in subsections (I) and (K)(3)(c), and the potential risks for declining a test, and, if a test is declined, the need for a written assertion of a pregnant woman's decision to decline testing;
   e. The requirement for consultation for a condition specified in R9-16-112; and
   f. The requirement for the transfer of care for a condition specified in R9-16-111; and
2. Obtain a written informed consent for midwifery services according to R9-16-109.

D. A midwife shall:

1. Establish an emergency care plan for a client that includes:
   a. The name of the client;
   b. The name of the midwife;
   c. The name, address, and phone number of:
      i. The hospital closest to the birthing location that provides obstetrical services, and
      ii. An emergency medical services provider that provides service between the birthing location and the hospital identified in subsection (D)(1)(c)(i);
   d. The signature of the client and the date signed; and
   e. The signature of the midwife and the date signed; and

2. For a delivery identified in subsection (B), ensure that the hospital identified in subsection (D)(1)(c)(i) is within 25 miles of the birthing location.

E. A midwife shall ensure the client receives a copy of the emergency care plan required in subsection (D).

F. A midwife shall implement the emergency care plan by immediately calling the emergency medical services provider identified in subsection (D)(1)(c)(ii) for any condition that threatens the life of the client or the client's fetus or newborn.

G. A midwife shall maintain all instruments used for delivery in a germ-free manner and other birthing equipment and supplies in clean and good condition.

H. A midwife shall assess a client's physical condition in order to establish the client's continuing eligibility to receive midwifery services.

I. During the prenatal period, the midwife shall:

1. Except as provided in R9-16-110, ensure that the following tests are completed by the client within 28 weeks gestation:
   a. Blood type, including ABO and Rh, with antibody screen;
   b. Urinalysis;
   c. HIV;
   d. Hepatitis B;
   e. Hepatitis C;
   f. Syphilis as required in A.R.S. § 36-693;
   g. Rubella titer;
   h. Chlamydia; and
   i. Gonorrhea;
2. Except as provided in R9-16-110, ensure that the following tests are completed by the client:
   a. A blood glucose screening test for diabetes completed between 24 and 28 weeks of gestation;
   b. A hematocrit and hemoglobin or complete blood count test completed between 28 and 36 weeks of gestation;
   c. A vaginal-rectal swab for Group B Strep Streptococcus culture completed between 35 and 37 weeks of gestation;
   d. At least one ultrasound and recommended follow-up testing to determine placental location and risk for placenta previa and placenta accrete; and
   e. An ultrasound at 36-37 weeks gestation to confirm fetal presentation and estimated fetal weight for a breech pregnancy;
3. Conduct a prenatal visit at least once every four weeks until the beginning of 28 weeks of gestation, once every two weeks from the beginning of 28 weeks until the end of 36 weeks of gestation, and once a week after 36 weeks of gestation that includes:

a. Taking the client's weight; urinalysis for protein, nitrites, glucose, and ketones; blood pressure; and assessment of the lower extremities for swelling;
b. Measurement of the fundal height and listening for fetal heart tones and, later in the pregnancy, feeling the abdomen to determine the position of the fetus;
c. Documentation of fetal movement beginning at 28 weeks of gestation;
d. Documentation of:
   i. The occurrence of bleeding or invasive uterine procedures, and
   ii. Any medications taken during the pregnancy that are specific to the needs of an Rh negative client;
e. Referral of a client for lab tests or other assessments, if applicable, based upon examination or history; and
f. Either:
   i. Recommendation of administration of Rh immunoglobulin to an unsensitized Rh negative client after 28 weeks, or any time bleeding or invasive uterine procedures are done; or
   ii. Midwife administration of Rh immunoglobulin under a physician's written orders;

4. Monitor fetal heart tones with a fetoscope;
5. Document the client's report of first quickening;
6. Conduct weekly visits until signs of first quickening have occurred if first quickening has not been reported by 20 weeks of gestation;
7. Initiate a consultation if first quickening has not occurred by the end of 22 weeks of gestation;
8. Conduct a prenatal visit of the birthing location before the end of 35 weeks of gestation to ensure that the birthing environment is appropriate for birth and that communication is available to the hospital and emergency medical services provider identified in subsection (D)(1)(c)(i) and (ii); and
9. Review with the client the circumstances when a transfer of care is required, as specified in R9-16-111.

J. During the intrapartum period from the onset of labor until after the delivery of the placenta, a midwife shall:

1. Determine if the client is in labor and the appropriate course of action to be taken by:
   a. Assessing the interval, duration, intensity, location, and pattern of the contractions;
   b. Determining the condition of the membranes, including whether the membranes are intact or ruptured, and the amount and color of fluid;
   c. Reviewing with the client the need for fluid intake related to subsection (J)(3)(d), relaxation, and activity; and
   d. Deciding whether to go to the client's home or other birthing location, remain in telephone contact, or arrange for transfer of care or consultation;
2. Contact the hospital identified in subsection (D)(1)(c)(i) according to the policies and procedures established by the hospital regarding communication with midwives when the client begins labor and ends labor;
3. During labor:

a. Assess the condition of the client and fetus:

i. Upon initial contact;

ii. Every half hour during active labor until completely dilated; and

iii. Every 15 to 20 minutes during pushing, following rupture of the amniotic bag, or until the newborn is delivered;

b. Include in the assessments required in subsection (J)(3)(a):

i. A physical assessment and checking of the client's vital signs every two to four hours; and

ii. Assessing fetal heart tones every 30 minutes during active first stage labor, and every 15 minutes during second stage labor, following rupture of the amniotic bag, or with any significant change in labor patterns;

c. Periodically assess contractions, fetal presentation, dilation, effacement, and fetal position by vaginal examination;

d. Maintain proper fluid balance for the client throughout labor as determined by urinary output and monitoring urine for presence of ketones; and

e. Assist in support and comfort measures to the client and family;

4. For deliveries described in subsection (B), during labor determine the progression of active labor:

a. For a pregnant woman giving birth to her first newborn, by monitoring whether dilation occurs at an average of one centimeter per hour until completely dilated, and a second stage does not exceed two hours;

b. For a pregnant woman who has previously given birth to one or more newborns, by monitoring whether dilation occurs at an average of 1.5 to two centimeters per hour until completely dilated, and a second stage does not exceed one hour; or

c. According to the Management Guidelines recommended by the American Congress of Obstetricians and Gynecologists;

5. After delivery of the newborn:

a. Assess the newborn at one minute and five minutes to determine the Apgar scores;

b. Physically assess the newborn for any abnormalities;

c. Inspect the client's perineum, vagina, and cervix for lacerations;

d. Deliver the placenta within 1 hour and assess the client for signs of placental separation from the inner wall of the uterus, resulting in vaginal or internal bleeding; and

e. Examine the placenta for intactness and to determine the number of umbilical cord vessels; and

6. Recognize and respond to any situation requiring immediate intervention, including measures to be taken during an emergency, as specified in R9-16-113.

K. During the postpartum period, the midwife shall:

1. During the 2 hours after delivery of the placenta, provide the following care to the client:

a. Every 15 to 20 minutes for the first hour and every 30 minutes for the second hour:
   i. Take vital signs of the client,
   ii. Perform external massage of the uterus, and
   iii. Evaluate bleeding;
b. Assist the client to urinate within 2 hours following the birth;
c. Evaluate the perineum, vagina, and cervix for tears, bleeding, or blood clots;
d. Assist with maternal-newborn bonding to develop a relationship between the client and newborn;
e. Assist with initial breast feeding, instructing the client in the care of the breast, and reviewing potential danger signs, if appropriate;
f. Provide instruction to the family about:
   i. Fluid and nutritional intake requirements to meet the needs of the mother and newborn;
   ii. Rest and the types of exercise allowed;
   iii. Normal and abnormal bleeding, bladder and bowel function;
   iv. How to care for the newborn;
   v. Signs and symptoms of postpartum depression; and
   vi. Any symptoms that may pose a threat to the health or life of the client or the client's newborn and appropriate emergency phone numbers;
g. Recommend, or administer under physician's written orders, Rh immunoglobulin to an unsensitized Rh-negative client who delivers an Rh-positive newborn so that administration occurs within 72 hours after birth; and
h. Document any medications taken by an unsensitized Rh-negative client who delivers an Rh-positive newborn in the client's record;

2. During the 2 hours after delivery of the placenta, provide the following care to the newborn:
   a. Perform a newborn physical assessment to determine the newborn's gestational age and any abnormalities;
   b. Comply with the requirements in A.A.C. R9-6-338;
   c. Recommend, or administer under physician's written orders, Vitamin K to the newborn so that administration occurs within 72 hours after birth; and
   d. Document the physical assessment and administration of any medications or vitamins to the newborn in the newborn's record according to the physician's written orders;
3. Evaluate the client or newborn for any abnormal or emergency situation and seek consultation or intervention, if applicable, according to these rules; and
4. Re-evaluate the condition of the client and newborn between 24 and 72 hours after delivery to determine whether the recovery is following a normal course, including:

a. Assessing baseline indicators such as the client's vital signs, bowel and bladder function, bleeding, breasts, feeding of the newborn, sleep/rest cycle, and activity, with any recommendations for change;
b. Assessing baseline indicators of well-being in the newborn such as vital signs, weight, cry, suck and feeding, fontanel, sleeping, and bowel and bladder function with documentation of meconium, and providing any recommendations for changes made to the family;
c. Submitting blood obtained from a heel stick to the newborn to the state laboratory for screening according to A.R.S. § 36-694(B) and 9 A.A.C. 13, Article 2, unless a written refusal is obtained from the client and documented in the client's record and the newborn's record; and
d. Recommending to the client that the client secure medical follow-up for her newborn.

L. A midwife shall request the registration of the birth of a newborn according to A.A.C. R9-19-203 within seven calendar days after the birth of the newborn.

R9-16-109. Informed Consent for Midwifery Services

A. A midwife shall obtain a written informed consent for midwifery services in a format provided by the Department that contains:
1. The midwife's:
   a. Name,
   b. Telephone number,
   c. License number, and
   d. E-mail address;
2. The client's:
   a. Name;
   b. Address;
   c. Telephone number;
   d. Date of birth; and
   e. E-mail address, if applicable;
3. An attestation that the client was:
   a. Provided the information required in R9-16-108(C)(1);
   b. Informed of the emergency care plan as required in R9-16-108(D); and
   c. Given an opportunity to have questions answered, have an understanding of the information provided, and choose to continue with midwifery services; and
4. The signatures of the client and midwife and date signed.

B. A midwife shall ensure that the written informed consent for midwifery services is placed in the client record.

C. A midwife shall ensure that a copy of the written informed consent for midwifery services is provided to the:
1. Client, and
2. Department within five calendar days after a Department request.

R9-16-110. Assertion to Decline Required Tests

A. Except for R9-16-108(I)(1)(f), if the client declines a test required in R9-16-108(I)(1) or (2), a midwife shall obtain a written assertion of a client's decision to decline a required test in a format provided by the Department, that contains:

1. The midwife's:
   a. Name,
   b. Telephone number,
   c. License number, and
   d. E-mail address;
2. The client's:
   a. Name;
   b. Address;
   c. Telephone number;
   d. Date of birth; and
   e. E-mail address, if applicable;
3. The required test being declined by the client;
4. Additional information as required by the Department;
5. An attestation that the client:
   a. Was provided the information as required in R9-16-108(C)(1)(d), and
   b. Is declining testing; and
6. The signatures of the client and midwife and date signed.

B. A midwife shall ensure that the written assertion of the decision to decline a test is placed in the client record.

C. A midwife shall ensure that a copy of the written assertion of the decision to decline a test is provided to the:

1. Client, and
2. Department within five calendar days after a Department request.

R9-16-111. Prohibited Practice; Transfer of Care

A. A midwife shall not provide midwifery services in a location that has the potential to cause harm to the client or the client's fetus or newborn.

B. A midwife shall not accept as a client for midwifery services a pregnant women who has any of the following:

1. A previous surgery that involved:
   a. An incision in the uterus, except as provided in R9-16-108(B)(1); or
   b. A previous uterine surgery that enters the myometrium;
2. A history of severe postpartum bleeding, of unknown cause, which required transfusion;
3. Gestational age greater than 34 weeks with no prior prenatal assessments or clinical examinations;
4. Multiple fetuses;

5. A pelvis that will not safely allow a fetus to pass through during labor;
6. Placenta previa or placenta accreta;
7. Deep vein thrombosis or pulmonary embolism;
8. Uncontrolled gestational diabetes;
9. Insulin-dependent diabetes;
10. Hypertension;
11. Rh disease with positive titers;
12. Active:
    a. Tuberculosis,
    b. Syphilis,
    c. Hepatitis until treated and recovered, or
    d. Gonorrhea until treated and recovered;
13. A blood pressure of 140/90 or an increase of 30 millimeters of Mercury systolic or 15 millimeters of Mercury diastolic over the client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart;
14. A persistent hemoglobin level below 10 grams;
15. A condition related to emotional or behavioral functioning, as a result of a mental disorder as defined in A.R.S. § 36-501, that:
    a. Is severe and persistent, resulting in a long-term limitation of the client's capacity for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, or recreation; and
    b. Impairs or substantially interferes with the client's capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration; or
16. Indications of the continued use of one of the following despite negative consequences, including six months prior to pregnancy, that is evident during an assessment of a client:
    a. Alcohol,
    b. Narcotics, or
    c. Other drugs.

C. A midwife shall not continue midwifery services for a client who is diagnosed with or develops any of the following:

1. Any condition specified in subsections (B)(4) through (16);
2. A hematocrit below 30 during the third trimester;
3. Except as provided in R9-16-108(B)(2), a fetus that is not in a head-down position with the crown of the head being the leading body part;
4. Labor beginning before the beginning of 36 weeks gestation;

5. A progression of labor that does not meet the requirements of R9-16-108(J)(4), if applicable;
6. A gestation beyond 42 weeks;
7. Presence of ruptured membranes without onset of labor within 24 hours;
8. Abnormal fetal heart rate consistently less than 120 beats per minute or more than 160 beats per minute;
9. Presence of thick meconium, blood-stained amniotic fluid, or abnormal fetal heart tones;
10. A postpartum hemorrhage of greater than 500 milliliters in the current pregnancy; or
11. A non-bleeding placenta retained for more than 60 minutes.

D. A midwife shall not perform a vaginal delivery after prior Cesarean section for a client who:

1. Had:
   a. More than one previous Cesarean section;
   b. A previous Cesarean section:
      i. With a classical, vertical, or unknown uterine incision;
      ii. Within 18 months before the expected delivery;
      iii. With complications, including uterine infection; or
      iv. Due to failure to progress as a result of cephalopelvic insufficiency; or
   c. Complications during a previous vaginal delivery after a Cesarean section; or
2. Has a fetus:
   a. With fetal anomalies, confirmed by an ultrasound; or
   b. In a breech presentation.

E. A midwife shall not perform a vaginal delivery of a fetus in a breech presentation for a client who:

1. Had a previous:
   a. Unsuccessful vaginal delivery or other demonstration of an inadequate maternal pelvis, or
   b. Cesarean section; or
2. Has a fetus:
   a. With fetal anomalies, confirmed by an ultrasound;
   b. With an estimated fetal weight less than 2500 grams or more than 3800 grams; or
   c. In an incomplete breech presentation.

F. If the client has any of the conditions in subsections (C) through (E), a midwife shall:

1. Document the condition in the client record, and
2. Initiate transfer of care.

G. A midwife shall not perform any operative procedures except as provided in R9-16-113.

H. A midwife shall not:

1. Use any artificial, forcible, or mechanical means to assist birth; or
2. Attempt to correct fetal presentations by external or internal movement of the fetus.

I. A midwife shall not administer drugs or medications except as provided in R9-16-108(I)(3)(f), (K)(1)(g), or (K)(2)(c), or R9-16-113.

J. Except as provided in R9-16-113, a midwife shall:

1. Discontinue midwifery services and transfer care of a newborn in which any of the following conditions are present:
   a. Birth weight less than 2000 grams;
   b. Pale, blue, or gray color after 10 minutes;
   c. Severe swelling, especially of the newborn's abdomen;
   d. Major congenital anomalies; or
   e. Respiratory distress; and
2. Document the condition in subsection (J)(1) in the newborn record.

R9-16-112. Required Consultation

A. A midwife shall obtain a consultation at the time a client is determined to have any of the following during the current pregnancy:

1. A positive culture for Group B Streptococcus;
2. History of seizure disorder;
3. History of stillbirth, premature labor, or having delivered more than five newborns;
4. Age younger than 16 years;
5. A first pregnancy in a client older than 40 years of age;
6. Failure to auscultate fetal heart tones by the beginning of 22 weeks gestation;
7. Failure to gain 12 pounds by the beginning of 30 weeks gestation or gaining more than eight pounds in any two-week period during pregnancy;
8. Greater than 1+ sugar, ketones, or protein in the urine on two consecutive visits;
9. Excessive vomiting or continued vomiting after the end of 20 weeks gestation;
10. Symptoms of decreased fetal movement;
11. A fever of 100.4° F or 38° C or greater measured twice at 24 hours apart;
12. Tender uterine fundus;
13. Effacement or dilation of the cervix, greater than a fingertip, accompanied by contractions, prior to the beginning of 36 weeks gestation;
14. Measurements for fetal growth that are not within 2 centimeters of the gestational age;
15. Second degree or greater lacerations of the birth canal;
16. Except as provided in R9-16-111(C)(4), a progression of labor that does not follow the guidelines in R9-16-108(J)(4)(c);
17. An unengaged head at seven centimeters dilation in active labor;
18. Failure of the uterus to return to normal size in the current postpartum period;

19. Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful;
20. Gonorrhea;
21. Chlamydia;
22. Syphilis;
23. Heart disease;
24. Kidney disease;
25. Blood disease; or
26. A positive test result for:
    a. HIV,
    b. Hepatitis B, or
    c. Hepatitis C.

B. A midwife shall obtain a consultation at the time a newborn demonstrates any of the following conditions:

1. Weight less than 2500 grams or five pounds, eight ounces;
2. Congenital anomalies;
3. An Apgar score less than 7 at five minutes;
4. Persistent breathing at a rate of more than 60 breaths per minute;
5. An irregular heartbeat;
6. Persistent poor muscle tone;
7. Less than 36 weeks gestation or greater than 42 weeks gestation by gestational exam;
8. Yellowish-colored skin within 48 hours;
9. Abnormal crying;
10. Meconium staining of the skin;
11. Lethargy;
12. Irritability;
13. Poor feeding;
14. Excessively pink coloring over the entire body;
15. Failure to urinate or pass meconium in the first 24 hours of life;
16. A hip examination which results in a clicking or incorrect angle;
17. Skin rashes not commonly seen in the newborn; or
18. Temperature persistently above 99.0° or below 97.6° F.

C. The midwife shall inform the client of the consultation required in subsections (A) or (B) and recommendations of the physician or certified nurse midwife.

D. The midwife shall document the consultation required in subsections (A) or (B) and recommendations received in the client record or newborn record, as specified in R9-16-115(B)(14) or (C)(7) as applicable.

R9-16-113. Emergency Measures

A. In an emergency situation in which the health or safety of the client or newborn are determined to be at risk, a midwife:

1. Shall ensure that an emergency medical services provider is called; and
2. May perform the following procedures as necessary:
   a. Cardiopulmonary resuscitation of the client or newborn with a bag and mask;
   b. Administration of oxygen at no more than eight liters per minute via mask for the client and five liters per minute for the newborn via neonatal mask;
   c. Episiotomy to expedite the delivery during fetal distress;
   d. Suturing of episiotomy or tearing of the perineum to stop active bleeding, following administration of local anesthetic, contingent upon consultation with a physician or certified nurse midwife, or physician's written orders;
   e. Release of shoulder dystocia, the wedging of the shoulders of the fetus in the client's pelvis in such a way that the fetus is unable to be born without emergency action, by utilizing:
      i. Hyperflexion of the client's legs to the abdomen,
      ii. Application of external pressure suprapubically,
      iii. Rotation of the nonimpacted shoulder until the impacted shoulder is released,
      iv. Delivery of the posterior shoulder,
      v. Application of posterior pressure on the anterior shoulder, or
      vi. Positioning of the client on all fours with the back arched;
   f. Manual exploration of the uterus for control of severe bleeding; or
   g. Manual removal of placenta.

B. A licensed midwife may administer a maximum dose of 20 units of pitocin intramuscularly, in 10-unit dosages each, 30 minutes apart, to a client for the control of postpartum hemorrhage, contingent upon physician or certified nurse midwife consultation and written orders by a physician, and arrangements for immediate transport of the client to a hospital.

C. A midwife shall document in the client's record any medications taken by a client for the control of postpartum hemorrhage.

R9-16-114. Midwife Report after Termination of Midwifery Services

A. A midwife shall complete a midwife report for each client, in a format provided by the Department, that includes the following:

1. The midwife's:
   a. First name,
   b. Last name, and
   c. License number;

2. The client's:
   a. Date of birth;
   b. Client number;
   c. Date of last menstrual period;
   d. Estimated date of delivery;
   e. Gravida, the number of times the client has been pregnant, including a current pregnancy, regardless of whether these pregnancies were carried to term;
   f. Para, the number of times the client has given birth at greater than 20 weeks of gestation, including viable and non-viable births, where multiples are counted as one birth; and
   g. If applicable, whether the client had a vaginal delivery after prior Cesarean section or vaginal delivery of a fetus in a complete breech or frank breech presentation;
3. A description of the maternal outcome, including any complications;
4. If a vaginal delivery after prior Cesarean section or vaginal delivery of a fetus in a complete breech or frank breech presentation:
   a. Rate of dilation, and
   b. Duration of second stage labor;
5. If applicable, the newborn's:
   a. Date of birth;
   b. Gender;
   c. Weight;
   d. Length;
   e. Head circumference;
   f. Designation of average, small, or large for gestational age;
   g. Apgar score at one minute;
   h. Apgar score at five minutes;
   i. Existence of complications;
   j. Description of complications, if applicable;
   k. Birth certificate filing date; and
   l. Birth certificate number, if available;
6. Whether the client required transfer of care and, if applicable:
   a. Method of transport,
   b. Type of facility or individual to which the midwife transferred care of the client,
   c. Name of destination,
   d. Time arrived at destination,
   e. Confirmation the emergency care plan was utilized, and

f. Medical reason for transfer of care;

7. The date midwifery services were terminated;
8. Reason for the termination of midwifery services;
9. If termination of midwifery services was due to a medical condition, the specific medical condition;
10. Whether information was provided on newborn screening; and
11. Whether newborn screening tests were ordered as required in A.R.S. § 36-694.

B. The midwife shall submit a midwife report for a client to the Department within 30 calendar days after the termination of midwifery services to the client.

R9-16-115. Client and Newborn Records

A. A midwife shall ensure that a record is established and maintained according to A.R.S. §§ 12-2291 and 12-2297 for each:

1. Client, and
2. Newborn delivered by the midwife from a client.

B. A midwife shall ensure that a record for each client includes the following:

1. The client's full name, date of birth, address, and client number;
2. Names, addresses, and telephone numbers of the client's spouse or other individuals designated by the client to be contacted in an emergency;
3. Written informed consent for midwifery services, as required in R9-16-108(C)(2);
4. If applicable, assertion to decline required tests, as required in R9-16-110(A);
5. A copy of the emergency care plan, as required in R9-16-108(D);
6. The date the midwife began providing midwifery services to the client;
7. The date the client is expected to deliver the newborn;
8. The date the newborn was delivered, if applicable;
9. An initial assessment of the client to:
   a. Determine whether the client has a history of a condition or circumstance that would preclude care of the client by the midwife, as specified in R9-16-111; and
   b. Determine the:
      i. Number and outcome of previous pregnancies, and
      ii. Number of previous medical or midwife visits the client has had during the current pregnancy;
10. Progress notes documenting the midwifery services provided to the client;
11. For a delivery identified in R9-16-108(B):
    a. Rate of dilation, and
    b. Duration of second stage labor;
12. Laboratory and diagnostic reports, required in R9-16-108(I);
13. Documentation of consultations as required in R9-16-112, including:

a. Reason for the consultation,
b. Name of physician or certified nurse midwife contacted,
c. Date of consultation,
d. Time of consultation,
e. Recommendation made by the physician or certified nurse midwife, and
f. Actions taken as a result of the consultation;

14. Any written reports received from consultations required in R9-16-112;
15. A description of any conditions or circumstances arising during the pregnancy that required the transfer of care;
16. The name of the physician, certified nurse midwife, or hospital to which the care of the client was transferred, if applicable;
17. Documentation of medications or vitamins taken by the client;
18. Documentation of medications or vitamins administered to the client and the physician's written orders for the medications or vitamins;
19. The outcome of the pregnancy;
20. The date the midwife stopped providing midwifery services to the client; and
21. Instructions provided to the client before the midwife stopped providing midwifery services to the client.

C. A midwife shall ensure that a record for each newborn includes the following:

1. The full name, date of birth, and address of the newborn's mother;
2. The newborn's:
   a. Date of birth,
   b. Gender,
   c. Weight at birth,
   d. Length at birth, and
   e. Apgar scores at one minute and five minutes after birth;
3. The newborn's estimated gestational age at birth;
4. Progress notes documenting the midwifery services provided to the newborn;
5. Laboratory and diagnostic reports, as required in R9-16-108(I);
6. Documentation of consultations as required in R9-16-112, including:
   a. Reason for the consultation,
   b. Name of physician or certified nurse midwife contacted,
   c. Date of consultation,
   d. Time of consultation,
   e. Recommendation made by the physician or certified nurse midwife, and
   f. Actions taken as a result of the consultation;

7. Any written reports received from consultations required in R9-16-112;
8. A description of any conditions or circumstances arising during or after the newborn's birth that required the transfer of care;
9. The name of the physician, certified nurse midwife, or hospital to which the care of the newborn was transferred, if applicable;
10. Documentation of medications or vitamins taken by the newborn;
11. Documentation of medications or vitamins administered to the newborn and the physician's written orders for the medications or vitamins;
12. Documentation of newborn screening, including when the specimen collection kit, as defined in A.A.C. R9-13-201, was submitted and results received, as required in R9-16-108(K)(4)(c);
13. The date the midwife stopped providing midwifery services to the newborn; and
14. Instructions provided to the client about the newborn before the midwife stopped providing midwifery services to the newborn.

R9-16-116. Denial, Suspension, or Revocation of License; Civil Penalties; Procedures

In addition to the grounds specified in A.R.S. §§ 13-904(E) and 36-756, the Department may deny, suspend, or revoke a license permanently or for a definite period of time, and may assess a civil penalty for each violation, for any of the following causes:

1. Practicing under a false name or alias so as to interfere with or obstruct the investigative or regulatory process,
2. Practicing under the influence of drugs or alcohol,
3. Falsification of records,
4. Obtaining any fee for midwifery services by fraud or misrepresentation,
5. Permitting another to use the midwife's license, or
6. Knowingly providing false information to the Department.