

**CALIFORNIA BOARD OF REGISTERED NURSING
GENERAL INSTRUCTIONS AND APPLICATION REQUIREMENTS
REGARDING NURSE-MIDWIFE (NM) CERTIFICATION**

GENERAL INSTRUCTIONS

I. General Application Requirements

Nurse-Midwife certification eligibility requires the possession of a current, clear and active California RN license. The following must be submitted to the Board of Registered Nursing for Nurse-Midwife certification purposes:

- 1. A completed Nurse-Midwife Certification Application form (Pages 6 & 7).**
- 2. Nurse-Midwife certification fee of \$75.00.**
- 3. One recent 2” x 2” passport type photograph.**
- 4. Required documentation to determine certification eligibility. Please refer to the application requirements for Nurse-Midwife certification (Pages 4 & 5) and select the appropriate method by which to qualify.**

If you do not possess a current, clear and active California RN license and have never applied for a California RN license, an Application for California RN Licensure by Endorsement must also be submitted. If you have had a permanent California RN license, you must renew/reactivate the California RN license.

Nurse-Midwife application fee is an earned fee; therefore, when an applicant is found ineligible the application fee is not refunded. Processing times for certification may vary, depending on the receipt of documentation from academic programs, associations/national organizations or evaluators. Processing a Nurse-Midwife certification application indicating a conviction(s), disciplinary action(s) and/or voluntary surrender(s) may take longer. A pending application file is not a public record; therefore, an applicant must sign a release of information before the Board of Registered Nursing will release information to the public, including employers, relatives or other third parties. Once you are certified, your address of record must be disclosed to the public upon request. All requests for information are mandatory.

GENERAL INSTRUCTIONS (CONT'D)

II. Name and/or Address Changes

California Code of Regulations, Section 1409.1 requires that you notify the Board of Registered Nursing of all names and address changes within thirty (30) days of any change. You may call the Board of Registered Nursing regarding the change of address of record. If you have changed your name, please submit a letter of explanation regarding the requested name change plus applicable documentation such as a copy of a marriage certificate, divorce decree or a driver's license.

III. Social Security Number

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c) (2) (C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure, certification or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. **If you fail to disclose your social security number, your application for initial or renewal of licensure/certification will not be processed.** You will be reported to the Franchise Tax Board, who may assess a \$100 penalty against you.

ALERT: Effective July 1, 2012, the Board of Registered Nursing is required to deny an application for licensure and to suspend the license/certification/registration of any applicant or licensee who has outstanding tax obligations due to the Franchise Tax Board (FTB) of the State Board of Equalization (BOE) and appears on either the FTB or BOE's certified lists of top 500 tax delinquencies over \$100.00. (AB 1424, Perea, Chapter 455, Statutes of 2011)

IV. Reporting ALL Conviction(s), Discipline(s) and/or Voluntary Surrender(s) Against Licenses/Certificates

Applicants are required under law to report **ALL** misdemeanor and felony convictions. "Driving under the influence: convictions must be reported, Conviction(s) must be reported even if they have been expunged under Penal Code Section 1203.4 or even if a court ordered diversion program has been completed under the Penal Code or under Article 5 of the Vehicle Code. Also, all disciplinary action(s) and/or voluntary surrender(s) against an applicant's clinical nurse specialist, registered nurse, practical nurse, vocational nurse or other professional license/certificate must be reported.

Failure to report prior conviction(s), disciplinary action(s) and/or voluntary surrender(s) is considered falsification of application and is grounds for denial of licensure/certification or revocation of license/certificate.

When reporting prior conviction(s), disciplinary action(s) and/or voluntary surrender(s), **applicants are required to provide a full written explanation of:** circumstances surrounding the arrest(s), conviction(s), disciplinary action(s) and/or voluntary surrender(s), the date of incident(s), conviction(s) disciplinary action(s) and/or voluntary surrender(s), specific violation(s) (cite section of law, if convicted), court location or jurisdiction, sanctions or penalties imposed and completion dates. Certified copies of court documents or state board determinations/decisions should also be included.

NOTE: A certified copy of the arrest report may also be requested. Applicants must also submit a description of the rehabilitative changes in their lifestyle which would enable them to avoid future occurrences.

GENERAL INSTRUCTIONS (CONT'D)

To make a determination in these cases, the Board of Registered Nursing consider the nature and severity of the offence, additional subsequent acts, recency of acts or crimes, compliance with course sanctions and evidence of rehabilitation.

The burden of proof lies with the applicant to demonstrate acceptable documented evidence of rehabilitation. Examples of rehabilitation evidence include, but are not limited to:

- Recent dated letter from applicant describing rehabilitative efforts or changes in life to prevent future problems
- Letters of reference on official letterhead from employers, nursing instructors, health professionals, professional counselors, parole or probation officers or other individuals in positions of authority who are knowledgeable about your rehabilitation efforts
- Letters from recognized recovery programs and/or counselors attesting to current sobriety and length of time of sobriety, if there is a history of alcohol or drug abuse.
- Proof of community work, schooling, self-improvement efforts
- Court issued certificate of rehabilitation or evidence of expungement, proof of compliance with criminal probation or parole and orders of the court

All of the above items should be mailed **directly** to the Board of Registered Nursing by the individual(s) or agency that is providing information about the applicant. Have these items sent to the Board of Registered Nursing, Advanced Practice Unit, PO Box 944210, Sacramento, CA 94244-2100.

It is the responsibility of the applicant to provide sufficient rehabilitation evidence on a timely basis so that a certification determination can be made.

An applicant is also required to immediately report in writing, to the Board of Registered Nursing any conviction(s), disciplinary action(s) and/or voluntary surrender(s) which occur between the date the application was filed and the date that a California Nurse-Midwife certificate is issued. Failure to report this information is grounds for denial of licensure/certification or revocation of license/certificate.

NOTE: The application must be completed and signed by the applicant under penalty of perjury.

V. Temporary Nurse-Midwife Certificate

The Temporary Nurse-Midwife Certificate (TCNM) is only applicable for the Nurse-Midwife certification applicant who does not possess a **permanent California RN license at the time of application.**

GENERAL INSTRUCTIONS (CONT'D)

VI. Address Information

The Board of Registered Nursing's mailing address is:

Advanced Practice Unit – NM Certification
Board of Registered Nursing
P. O. Box 944210, Sacramento, CA 94244-2100

The Board of Registered Nursing's street address for overnight mail is:

Advanced Practice Unit – NM Certification
Board of Registered Nursing
1747 North Market Blvd., Suite 150, Sacramento, CA 95834

VII. California Nursing Practice Act

California statutes and regulations pertaining to Registered Nurses/Nurse-Midwives may be obtained by contacting:

LexisNexis at:
www.lexisnexis.com/bookstore (search: California Nursing)

APPLICATION REQUIREMENTS FOR NURSE-MIDWIFE (NM) CERTIFICATION

METHOD ONE

Successful completion of the nurse-midwifery academic program of study which conforms with the Board's educational standards set forth in the California Code of Regulations Section 1462.

Documentation submitted directly to the Board of Registered Nursing:

1. Verification of the Completion of a Nurse-Midwifery Academic Program form submitted by the nurse-midwifery academic program. (Page 8)
2. Official transcripts for the completed nurse-midwifery academic program submitted by the nurse-midwifery academic program.
3. Verification of Nurse-Midwifery Clinical Recency form submitted by the verifier, if the nurse-midwifery academic program was completed more than one (1) year ago at the time of application. (Page 12)

APPLICATION REQUIREMENTS FOR NURSE-MIDWIFE (NM) CERTIFICATION

METHOD TWO

Completion of a nurse-midwifery academic program which conforms with the Board's educational standards as set forth in the California Code of Regulations Section 1462, but **not** Board approved. Remediation of deficiencies may be required through a Board of Registered Nursing approved program/course.

Documentation submitted directly to the Board of Registered Nursing:

1. Verification of the Content of the Nurse-Midwifery Academic Program form submitted by the nurse-midwifery academic program. (Pages 9 & 10)
2. Official transcripts for the completed nurse-midwifery academic program submitted by the nurse-midwifery academic program.
3. Verification of Nurse-Midwifery Clinical Recency form submitted by the verifier, if the nurse-midwifery academic program was completed more than one (1) year ago at the time of application. (Page 12)
4. If applicable, a copy of the nurse-midwife certificate from the state/country that allowed you to practice nurse-midwifery.

METHOD THREE

Certification by a state or national organization/association whose standards are equivalent to those set forth in the California Code of Regulations Section 1462.

Documentation submitted directly to the Board of Registered Nursing:

1. Verification of Nurse-Midwife Certification by a National Organization/Association form submitted by the national association. (Page 11)
2. Verification of the Completion of a Nurse-Midwifery Academic Program form submitted by the nurse-midwifery academic program. (Page 8)
3. Official transcripts for the completed nurse-midwifery academic program submitted by the nurse-midwifery academic program.
4. Verification of Nurse-Midwifery Clinical Recency form submitted by the verifier, if the nurse-midwifery academic program was completed more than one (1) year ago at the time of application. (Page 12)

The national organization/association listed below has met the certification requirements that are equivalent to the Board's standards for nurse-midwife certification:

AMERICAN MIDWIFERY CERTIFICATION BOARD (AMCB)
849 International Drive, Suite 205, Linthicum, MD 21090
Phone: (401) 694-9424 Fax: (410) 694-9425
www.amcbmidwife.org

(Above Information Subject to Change)

APPLICATION FOR NURSE-MIDWIFE (NM) CERTIFICATION
APPLICATION FEE - \$75.00

A. PERSONAL DATA (Please print or type):

Name: <div style="display: flex; justify-content: space-between; width: 100%;"> (Last) (First) (Middle) </div>	Previous Names (Including Maiden):
Address of Record: <div style="text-align: center;">(Number & Street)</div>	Date of Birth: <div style="display: flex; justify-content: space-between; width: 100%;"> (Month) (Day) Year </div>
 <div style="display: flex; justify-content: space-between; width: 100%;"> (City) (State) (Zip Code) </div>	Social Security Number (Mandatory):
Telephone Number: Home () Work ()	Mother's Maiden Name:

B. RN LICENSURE/NURSE-MIDWIFE CERTIFICATION:

California RN License Number:	Date Issued:	Expiration Date:
List ALL States Where You Hold/Held an RN License and Status:	List ALL States Where You Hold/Held a Nurse-Midwife License/Certificate and Status:	
Original State of RN Licensure:	Date Issued:	Expiration Date:
RN License Number:	Date Issued:	Expiration Date:
Original State of Nurse-Midwife Certification:	Date Issued:	Expiration Date:
Nurse-Midwife Certificate Number:	Date Issued:	Expiration Date:

C. RN EDUCATION:

Name of Professional Registered Nursing Program:	Location: <div style="display: flex; justify-content: space-between; width: 100%;"> (City) (State or Country) </div>
Type of RN Program: <input type="checkbox"/> ADN <input type="checkbox"/> DIP <input type="checkbox"/> BSN <input type="checkbox"/> MSN	Entrance Date: Graduation/Completion Date:

D. NURSE-MIDWIFERY EDUCATION:

Name of Nurse-Midwifery Academic Program:	Location: <div style="display: flex; justify-content: space-between; width: 100%;"> (City) (State or Country) </div>
Type of Nurse-Midwifery Academic Program: <input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's	Entrance Date: Graduation/Completion Date:

E. NURSE-MIDWIFE PROFESSIONAL CERTIFICATION (If Applicable):

Name of Organization/Association:	Original Date of Certification:
Certification Number:	Current Renewal/Recertification Cycle Dates:
Method of Certification: <input type="checkbox"/> Examination <input type="checkbox"/> Other (Please Explain)	

F. BACKGROUND INFORMATION:

I. Have you ever applied for a Nurse-Midwife certificate in California? If yes: Name at Time of Application: _____ Date Submitted: _____	Yes No <input type="checkbox"/>
II. Have you ever been issued a Nurse-Midwife certificate in California? If yes: STOP. DO NOT CONTINUE. Please contact the Board regarding whether you should reapply or file a petition for reinstatement of your California Nurse-Midwife certification.	Yes <input type="checkbox"/> No <input type="checkbox"/>
III. Have you ever been convicted of ANY offense other than minor traffic violations? If yes, please explain fully as described in the General Instructions – Section IV. Convictions must be reported even if they have been expunged under Penal Code Section 1203.4 or if a diversion program has been completed under the Penal Code or Article 5 of the Vehicle Code. Traffic violations involving driving under the influence, injury to persons or providing false information must be reported. The definition of conviction includes convictions following a plea of nolo contendere (no contest), as well as pleas or verdicts of guilty. YOU MUST INCLUDE MISDEMEANORS AS WELL AS FELONY CONVICTIONS.	Yes <input type="checkbox"/> No <input type="checkbox"/>
IV. Have you ever had a health-care related license/certificate to practice nursing revoked, suspended, placed on probation or otherwise disciplined or voluntarily surrendered in any way? If yes, please explain fully as described in the General Instructions – Section IV.	Yes <input type="checkbox"/> No <input type="checkbox"/>
V. Have you ever had a professional or vocational license/certificate to practice revoked, suspended, placed on probation or otherwise disciplined or voluntarily surrendered in any way? If yes, please explain fully as described in the General Instructions – Section IV.	Yes <input type="checkbox"/> No <input type="checkbox"/>

I understand that I am required to report immediately to the California Board of Registered Nursing if I am convicted of **ANY** offense that occurs between the date of this application and the date that a California Nurse-Midwife certificate is issued. I am also required to report to the California Board of Registered Nursing **ANY** disciplinary action and/or voluntary surrender against **ANY** health-care related license/certificate that occurs between the date of this application and the date that a California Nurse-Midwife certificate is issued. I understand that failure to do so may result in denial of this application or subsequent disciplinary action against my license/certificate.

I certify, under penalty of perjury under the laws of the State of California, that all information provided in connection with this application for Nurse-Midwife certification is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure/certification or licensure/certification revocation in California.

SIGNATURE OF APPLICANT: _____

DATE: _____

<p>NOTE:</p> <p>PLEASE TAPE A RECENT 2" x2" PASSPORT SIZE PHOTOGRAPH</p>
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**VERIFICATION OF THE COMPLETION OF
A NURSE-MIDWIFERY (NM) ACADEMIC PROGRAM**

A. TO BE COMPLETED BY APPLICANT: Please complete Section A and forward to the program director/representative for the nurse-midwifery academic program for completion. Official transcripts submitted must include all completed course work with the certificate/degree status conferred and must be sent directly to the Board of Registered Nursing by the Registrar's Office/Transcript Office. A processing fee may be required for the submission of the official transcripts. Please print or type.

Name: (Last) (First) (Middle)	Previous Names (Including Maiden Name):
Address: (Number & Street)	Date of Birth: (Month) (Day) (Year)
(City) (State) (Zip Code)	Social Security Number (Mandatory):
Telephone Number: Home Work	California RN License Number: Expiration Date:
Name of Nurse-Midwifery Academic Program:	
Entrance and Completion Dates:	Type of Program:
Signature of Applicant: _____ Date: _____	

B. TO BE COMPLETED BY THE PROGRAM DIRECTOR/REPRESENTATIVE FOR THE NURSE-MIDWIFERY ACADEMIC PROGRAM: Please complete Part B regarding the above named applicant and return to the Board of Registered Nursing.

Name of Nurse-Midwifery Academic Program:	Telephone Number:
Address: (Number & Street) (City) (State) (Zip Code)	
Type of Program: <input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's	
Entrance and Completion Dates: From: To: (Month) (Day) (Year) (Month) (Day) (Year)	
Date Certificate/Degree Status Conferred: (If conferral date and/or status not posted to transcript, please explain.)	
I certify under penalty of perjury that the documentation regarding the completion of the nurse-midwifery academic program for the above named applicant is true and correct.	
Signature: _____ Date: _____	
Title: _____ Telephone Number:(_____)	

VERIFICATION OF THE CONTENT OF THE NURSE-MIDWIFERY (NM) ACADEMIC PROGRAM METHOD 2

A. TO BE COMPLETED BY APPLICANT: Please complete Section A and forward to the program director/representative for the nurse-midwifery academic program for completion. Official transcripts submitted must include all completed course work with the certificate/degree status conferred and must be sent directly to the Board of Registered Nursing by the Registrar's Office/Transcript Office. A processing fee may be required for the submission of the official transcripts. Please print or type.

Name: (Last) (First) (Middle)	Previous Names (Including Maiden Name):
Address: (Number & Street)	Date of Birth: (Month) (Day) (Year)
(City) (State) (Zip Code)	Social Security Number (Mandatory):
Name of Nurse-Midwifery Academic Program:	
Entrance and Completion Dates:	Type of Program:
Signature of Applicant: _____ Date: _____	

B. TO BE COMPLETED BY THE PROGRAM DIRECTOR/REPRESENTATIVE FOR THE NURSE-MIDWIFERY ACADEMIC PROGRAM: Please complete Part B regarding the above named applicant and return to the Board of Registered Nursing.

Name of Nurse-Midwifery Academic Program:	Telephone Number: ()
Address: (Number & Street) (City) (State or Country) (Zip Code)	
Type of Nurse-Midwifery Academic Program: <input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's	
Entrance and Completion Dates: From: To: (Month) (Day) (Year) (Month) (Day) (Year)	
Date Certificate/Degree Status Conferred: (If conferral date and/or status not posted to transcript, please explain.)	

Please review the list of the California educational requirements **on the reverse side of this form**. Place a check mark (✓) next to each subject included in the completed nurse-midwifery academic program and then mark the appropriate box below:

The applicant's nurse-midwifery academic program **included** all the subjects listed on the reverse side of this form.

The applicant's nurse-midwifery academic program **did not include** all the subjects listed on the reverse side of this form.

I certify under penalty of perjury that the verification regarding the subjects included in the nurse-midwifery academic program for the above named applicant is true and correct.

Signature: _____ Title: _____
Date: _____ Telephone Number: (_____) _____

CALIFORNIA EDUCATIONAL REQUIREMENTS FOR NURSE-MIDWIFERY ACADEMIC PROGRAMS

Please check (✓) subjects included in the applicant's nurse-midwifery academic program.

A. General Subjects

- Nurse-Midwifery Management Process
- Anatomy and Physiology
- Genetic Counseling/Antepartum Evaluation
- Embryology and Fetal Development
- Child Growth and Development
- Concepts of Psycho-Social, Emotional and Cultural Aspects of:**
 - Maternal/Child Care
 - Human Sexuality
 - Counseling and Teaching
 - Maternal/Infant/Family Bonding Process
 - Breast Feeding
 - Family Planning
 - Principles of Preventive Health
 - Community Health; Including Substance Abuse and Environmental Hazards
- Sexually Transmitted Diseases
- Universal Precautions

B. Management of Normal Pregnancy

- Physiology
- Physical Assessment
- Laboratory & Diagnostic Tests and Procedures
- Obstetrics
- Pharmacology
- Emergencies
- Assessment of Mental and Emotional Status
- Nutrition

C. Management of Normal Labor and Delivery

- Physiology
- Physical Assessment
- Laboratory & Diagnostic Tests and Procedures
- Obstetrics
- Pharmacology
- Emergencies
- Assessment of Mental and Emotional Status
- Nutrition
- Administration of Intravenous Fluids, Analgesics, and Postpartum Oxytocics
- Amniotomy During Labor
- Application of External and Internal Monitoring Devices
- Administration of Perineal Anesthesia
 - Pudendal Block
 - Local Infiltration
- Episiotomy
- Repair of Episiotomies and Lacerations

D. Management of Normal Postpartum Period

- Physiology
- Physical Assessment
- Laboratory & Diagnostic Tests and Procedures
- Obstetrics
- Pharmacology
- Emergencies
- Assessment of Mental and Emotional Status
- Nutrition

E. Management of Routine Gynecological Care And Family Planning

- Physiology
- Physical Assessment
- Laboratory & Diagnostic Tests and Procedures
- Pharmacology
- Emergencies
- Assessment of Mental and Emotional Status
- Nutrition
- Gynecology
- Selection & Implementation of Birth Control Methods:**
 - Natural
 - Hormonal
 - Barrier
 - Diaphragm (Including Fitting)
 - IUD (Including Insertion)
 - Permanent

F. Management of Normal Newborn Care

- Physiology
- Physical Assessment
- Laboratory & Diagnostic Tests and Procedures
- Pharmacology
- Emergencies
- Newborn Resuscitation
- Nutrition, Feeding
- Neonatology

**VERIFICATION OF NURSE-MIDWIFE (NM) CERTIFICATION
BY A NATIONAL ORGANIZATION/ASSOCIATION**

METHOD 3

A. TO BE COMPLETED BY APPLICANT: Please complete Part A and submit to the applicable national organization/association to verify your nurse-midwife certification status. **A fee may be required by the national organization/association for the processing of the verification form.** Please print or type.

Name: (Last) (First) (Middle)			Previous Names (Including Maiden Name):		
Address: (Number & Street)			Date of Birth: (Month) (Day) (Year)		
(City) (State) (Zip Code)			Social Security Number (Mandatory):		
Telephone Number: Home Work			California RN License Number: Expiration Date:		
Name of Nurse-Midwifery Academic Program:					
Entrance and Completion Dates:				Type of Program:	
Signature of Applicant: _____ Date: _____					

B. TO BE COMPLETED BY THE CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION: Please complete Part B regarding the above named applicant and return to the Board of Registered Nursing.

Name of Certifying National Organization/Association:				Telephone Number: ()	
Address: (Number & Street) (City) (State) (Zip Code)				Method of Certification:	
Certificate Number:			Original Date of Certification:		
Current Renewal Cycle Dates for Certification/Recertification: From: To: (If not applicable, please explain.) (Month) (Year) (Month) (Year)					

I certify under penalty of perjury that the documentation regarding the nurse-midwife certification status for the above named applicant is true and correct.

Signature: _____ Date: _____

Title: _____ Telephone Number:(_____) _____ **(OFFICIAL SEAL)**

VERIFICATION OF NURSE-MIDWIFERY (NM) CLINICAL REGENCY

A. TO BE COMPLETED BY APPLICANT: Please complete Part A and submit to the appropriate verifier to evidence your clinical recency within the last five (5) years, if the nurse-midwifery academic program was completed more than one (1) year ago at the time of application. Please print or type.

Name: (Last) (First) (Middle)			Previous Names (Including Maiden Name):		
Address: (Number & Street)			Date of Birth: (Month) (Day) (Year)		
(City) (State) (Zip Code)			Social Security Number (Mandatory):		
Telephone Number: Home Work		California RN License Number: Expiration Date:			
Name of Nurse-Midwifery Academic Program:					
Entrance and Completion Dates:				Type of Program:	
Signature of Applicant: _____					Date: _____

B. VERIFICATION OF NURSE-MIDWIFERY CLINICAL REGENCY: Please complete Part B and return the completed form to the Board of Registered Nursing.

Name of Verifier: _____		Telephone Number: (____) _____			
Address: _____ (Number & Street) (City) (State) (Zip Code)					
Profession: _____			Licensed By: _____		
License Number: _____		Expiration Date: _____		Social Security Number: _____	
Location of Nurse-Midwifery Clinical Experience: _____ (Name of Agency) (Address)					
Level of Supervision Provided: _____					
From: _____ (Month) (Day) (Year)		To: _____ (Month) (Day) (Year)		For: _____ (Number)	
				Hours Per Week = _____ (Cumulative Hours)	
Summary of the nurse-midwifery clinical practice engaged in within the last five (5) years by the above named applicant: _____ _____ _____					
I certify under penalty of perjury that the above verification of nurse-midwifery clinical recency for the specified period for the above named applicant is true and correct.					
Signature: _____					Date: _____

APPLICATION FOR TEMPORARY NURSE-MIDWIFE (NM) CERTIFICATE

INSTRUCTIONS:

1. The application fee for the Temporary Nurse-Midwife Certificate (TC/NM) is **\$30.00**.
2. The TC/NM will not be issued until the **California RN Endorsement Application** and the **Application for Nurse-Midwife Certification** are complete. Only the fingerprint cards submitted to the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) for processing are still pending.
3. The TC/NM will not be mailed to an in-care-of address or a third party address.
4. Possession of a current and active California Temporary RN License (TL) is required.

PLEASE NOTE: IF YOU ALREADY POSSESS A PERMANENT CALIFORNIA RN LICENSE, YOU ARE NOT ELIGIBLE FOR THE TEMPORARY NURSE-MIDWIFE CERTIFICATE (TC/NM) AND YOUR APPLICATION FEE FOR THE TC/NM WILL NOT BE REFUNDED.

TO BE COMPLETED BY THE APPLICANT: Please print or type.

Name: <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 40px;"> (Last) (First) (Middle) </div>		Previous Names (Including Maiden Name):
Address: <div style="display: flex; justify-content: center; width: 80%; margin-left: 40px;"> (Number & Street) </div>		Date of Birth: <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 40px;"> (Month) (Day) (Year) </div>
<div style="display: flex; justify-content: space-between; width: 80%; margin-left: 40px;"> (City) (State) (Zip Code) </div>		Social Security Number (Mandatory):
Telephone Number: Home Work	California Temporary RN License Number: Expiration Date:	
Name of Nurse-Midwifery Academic Program:		
Address:		
Type of Program: <input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's	Entrance Date: Completion Date:	
I certify under penalty of perjury that the above information regarding the Application for the Temporary Nurse-Midwife Certificate is true and correct.		
Signature of Applicant: _____		Date: _____



BOARD OF REGISTERED NURSING
 PO Box 944210, Sacramento, CA 94244-2100
 P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov
 Louise R. Bailey, MEd, RN, Executive Officer

INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

Agency Name:		BOARD OF REGISTERED NURSING	
Title of official responsible for information maintenance:		EXECUTIVE OFFICER	
Address:	Telephone Number:		
P.O. BOX 944210, SACRAMENTO, CA 94244-2100	(916) 322-3350		
Authority which authorizes the maintenance of the information: SECTION 30, SECTION 2732.1(a), BUSINESS AND PROFESSIONS CODE			
ALL INFORMATION IS MANDATORY.			
The consequences, if any of not providing all or any part of the requested information: FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.			
The principal purpose(s) for which the information is to be used: TO DETERMINE ELIGIBILITY FOR LICENSURE. YOUR SOCIAL SECURITY NUMBER WILL BE USED FOR PURPOSES OF TAX ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 94-455 (42 USCA 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR SOCIAL SECURITY NUMBER. IF YOU FAIL TO DISCLOSE YOUR SOCIAL SECURITY NUMBER, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A \$100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST IF AND WHEN YOU BECOME LICENSED.			
Any known or foreseeable interagency or intergovernmental transfer which may be made of the information: POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING SOCIAL SECURITY NUMBER TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.			
EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.			

MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a “Mandated Reporter” for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Section 11166 and will comply with those provisions.

California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicably possible by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars (\$1,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11164, and subsequent sections.