



# MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246

Telephone (612) 617-2130 • Fax (612) 617-2166 • [www.bmp.state.mn.us](http://www.bmp.state.mn.us)

MN Relay Service for Hearing Impaired (800) 627-3529

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## Traditional Midwife Advisory Council Meeting Dates and Deadlines

Upon receipt of your application and documentation, you will be put on the next Council and Board agendas unless you specify a particular Board. It is your responsibility to make sure your file is complete; i.e. verifications, completed application, and documentation have been received by the Board. As a general rule, the application and documentation must be received two weeks prior to the next Council meeting as indicated below.

<u>MW Document Deadline</u>	<u>Council Meeting</u>	<u>Board Meeting</u>
November 11, 2013	November 25, 2013	January 11, 2014
January 5, 2014	January 27, 2014	March 8, 2014
March 10, 2014	March 31, 2014	May 10, 2014
May 21, 2014	June 2, 2014	July 12, 2014
July 14, 2014	July 28, 2014	September 13, 2014
September 15, 2014	September 29, 2014	November 8, 2014
November 10, 2014	November 24, 2014	January 10, 2015

2015 Dates to be Determined

**All Midwifery Licenses  
Expire June 30<sup>th</sup> of Each Year**



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## TRADITIONAL MIDWIFE INSTRUCTIONS

Enclosed is your application for licensure as a traditional midwife. Please thoroughly review the enclosed materials before submitting your application. Any processing fees incurred are your responsibility. The board reserves the right to reject any outdated applications submitted; therefore, it is recommended that you use the application in a timely manner. Incomplete applications will be destroyed after six months of inactivity.

### METHODS OF LICENSURE

The Board of Medical Practice is charged with administering the traditional midwife law. The law established eligibility for licensure through two different avenues. Applicants must select one and indicate your choice on the application.

#### A. General licensure

- Certification of Midwifery Educational Accreditation Council (MEAC) accredited program and a *notarized* copy of midwifery diploma or *notarized* written verification of having completed an apprenticeship
- Current certification of valid and current North American Registry of Midwives (NARM) credential as a certified professional midwife (*also serves as documentation verifying the practical experience requirement*)

#### B. Licensure by reciprocity

- Certification of Midwifery Educational Accreditation Council (MEAC) accredited program and a *notarized* copy of midwifery diploma or evidence of having completed an apprenticeship
- Current and unrestricted license from another state which requires NARM accredited program and NARM certification as a certified professional midwife
- Current certification of valid and current North American Registry of Midwives (NARM) credential as a certified professional midwife (*also serves as documentation verifying the practical experience requirement*)

### IN ADDITION TO THE DOCUMENTATION REQUIREMENTS SET FORTH UNDER LICENSURE REQUIREMENTS A-B, ALL OF THE FOLLOWING REQUIREMENTS MUST BE MET BEFORE PERMANENT LICENSURE CAN BE ISSUED:

- *Notarized* copy of current certification from the American Heart Association or the American Red Cross for adult and infant cardiopulmonary resuscitation
- Medical consultation plan
- **Recommendations** from two physicians, lay midwives or other health care professional who is knowledgeable regarding applicant's professional conduct and character during the last five years and is not a family member.
- *Notarized* copy documenting name change, if name different from diploma or certificate
- A full face, recent, 2x3" photograph must be affixed as indicated on the application and *notarized* as a true likeness
- *Notarized* copy of military discharge papers, if applicable
- All your time must be accounted for on the application, from high school to the date of application. During continuous years of education, period of three months or less (summer break) need not be accounted for
- Non-refundable fee of \$110 (application fee) and \$110 annual registration fee
- Any other information requested by the board

### **Temporary Permit for General and Reciprocity Applicants**

A temporary permit is available to applicants who have met all applicable requirements and a nonrefundable fee has been paid. The permit remains valid only until the board meeting at which a decision is made on the application.

### **APPROVAL PROCESS**

Applicants are granted permanent licensure by the Board of Medical Practice six times per year at board meetings. In order to be granted permanent licensure by the board, the Advisory Council on Licensed Traditional Midwives must first approve your application and recommend approval to the board. Council meetings are held 2-3 weeks before board meetings. Board meetings are held during every even-numbered month generally on the second Saturday. For an application to be reviewed by the council, the applicant must meet all application filing deadlines associated with that particular council meeting date.

### **BOARD MEETINGS AND DEADLINES**

Upon receipt of your application and documentation, you will be put on the next council and board agendas unless you specify a particular board. It is your responsibility to make sure your file is complete; i.e. verifications, completed application, exam scores, and documentation have been received by our board. Applicants with incomplete files will not be put on the council and board agendas. The council generally meets the middle of the even-numbered months and the board generally meets the second Saturday on odd-numbered months. As a general rule, the application and documentation must be received two weeks prior to the next council meeting.

### **APPLICATION FEES**

Please be aware that all fees are non-refundable. Fees submitted will not be refunded if it is determined that you are not eligible for registration.

#### **Permanent licensure application fee: \$220 (\$110 application + \$110 annual)**

This fee must be sent with a completed Application for Licensure form. Applicants who apply for a temporary permit must also submit an application for permanent license.

#### **Temporary permit fee: \$75**

This fee must be sent with a complete Temporary Permit Application form.

#### **Inactive status fee: \$50**

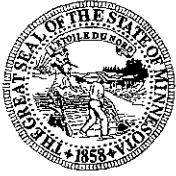
### **HOW TO APPLY**

If you qualify for licensure and would like an application or if you have specific questions about the application process and would like to talk to someone about them, please call the board at 612-617-2130. Address all written correspondence to:

MN Board of Medical Practice-Midwifery Licensure  
University Park Plaza  
2829 University Ave SE-Suite 500  
Minneapolis, MN 55414-3246

Written notification of any name or address change must be submitted to the board within 30 days. The law takes precedence over any conflicts between these instructions and the law.

3/2013



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## TRADITIONAL MIDWIFE FACT SHEET

### HISTORY

The Minnesota Legislature enacted a law in 1999 establishing a licensure system for traditional midwives. The Board of Medical Practice is responsible for administering the law and providing information to consumers and other interested persons.

### ADVISORY COUNCIL ON LICENSED TRADITIONAL MIDWIFERY

The Advisory Council on Licensed Traditional Midwifery was appointed by the Board of Medical Practice to advise the Board on issues regarding traditional midwife licensure standards, enforcement of the practice act, and complaint review. The Council is composed of five members: three traditional midwives, one physician who has been or is currently consulting with licensed traditional midwives, and one homebirth parent.

### LICENSURE

It is unlawful for any person to use the following protected titles without a valid license after June 30, 2001. An unlicensed person is prohibited from using the title "licensed traditional midwife," or "licensed midwife" or use the letters "LTM" or "LM" or any other titles words, letters, abbreviations, or insignia indicating or implying that the person is licensed as a traditional midwife in Minnesota. An unlicensed person violating this law is guilty of a misdemeanor.

### LICENSURE REQUIREMENTS

- A. General Licensure.** To establish eligibility for licensure, an applicant must:
1. be a graduate of an approved education program or submit evidence of having completed an apprenticeship;
  2. be currently certified by the North American Registry of Midwives (NARM) as a certified professional midwife;
  3. be currently certified by the American Heart Association or the American Red Cross for adult and infant cardiopulmonary resuscitation;
  4. submit a copy of their medical consultation plan;
  5. submit documentation verifying the required practical experience.
- B. Licensure by Reciprocity.** Applicant must have current and unrestricted license or certificate from another jurisdiction with requirements which meet or exceed Minnesota licensure requirements:
1. be a graduate of an approved education program or submit evidence of having completed an apprenticeship;
  2. be currently certified by the North American Registry of Midwives (NARM) as a certified professional midwife;
  3. be currently certified by the American Heart Association or the American Red Cross for adult and infant cardiopulmonary resuscitation;
  4. submit a copy of their medical consultation plan;
  5. submit documentation verifying the required practical experience.

- C. Licensure by Equivalency during Transitional Period.** Applicant must submit application by July 1, 2001 AND submit documentation of practicing traditional midwifery for at least 5 years from July 1, 1994 to June 30, 1999. Licensure during transition may be renewed once. Within a two year period from date license is issued, the licensed traditional midwife must obtain certification from the North American Registry of Midwives as a certified professional midwife.

### **LIMITED LICENSE**

A **temporary permit** is available to general and reciprocity applicants who meet all the requirements for permanent licensure and wish to practice before final approval is granted by the board. The temporary permit is valid only until the Board meeting at which a decision is made on the application for licensure.

### **SCOPE OF PRACTICE**

The scope of practice of traditional midwives includes, but is not limited to: 1) initial and ongoing assessment for suitability of traditional midwifery care; 2) providing prenatal education and coordinating with a licensed health care provider as necessary to provide comprehensive prenatal care, including the routine monitoring of vital signs, indicators of fetal developments, and laboratory tests, as needed, with attention to the physical, nutritional, and emotional needs of the woman and her family; 3) attending and supporting the natural process of labor and birth; 4) postpartum care of the mother and an initial assessment of the newborn, and 5) providing information and referrals to community resources on childbirth preparation, breast-feeding exercise, nutrition, parenting, and care of the newborn.

### **PRACTICE LIMITATIONS**

The practice of traditional midwifery does not include: 1) the use of any surgical instrument at a childbirth, except as necessary to sever the umbilical cord or repair a first- or second-degree perineal laceration; 2) the assisting of childbirth by artificial or mechanical means; or 3) the removal of a placenta accreta.

A licensed traditional midwife shall not prescribe, dispense, or administer prescription drugs, except that a licensed traditional midwife may administer vitamin K either orally or through intramuscular injection, postpartum antihemorrhagic drugs under emergency situations, local anesthetic, oxygen, and a prophylactic eye agent to the newborn infant. A licensed traditional midwife shall not perform any operative or surgical procedures except for suture repair of first- or second-degree perineal lacerations.

### **PROFESSIONAL CONDUCT (Statute 147D.05)**

Subdivision 1. **Practice standards.** (a) A licensed traditional midwife shall provide an initial and ongoing screening to ensure that each client receives safe and appropriate care. A licensed traditional midwife shall only accept and provide care to those women who are expected to have a normal pregnancy, labor, and delivery. As part of the initial screening to determine whether any contraindications are present, the licensed traditional midwife must take a detailed health history that includes the woman's social, medical, surgical, menstrual, gynecological, contraceptive, obstetrical, family, nutritional, and drug/chemical use histories. If a licensed traditional midwife determines at any time during the course of the pregnancy that a woman's condition may preclude attendance by a traditional midwife, the licensed traditional midwife must refer the client to a licensed health care provider. As part of the initial and ongoing screening, a licensed traditional midwife must recommend that the client receive the following services, if indicated, from an appropriate health care provider:

- (1) initial laboratory pregnancy screening, including blood group and type, antibody screen, Indirect Coombs, rubella titer, CBC with differential and syphilis serology;
- (2) gonorrhea and chlamydia cultures;
- (3) screening for sickle cell;
- (4) screening for hepatitis B and human immunodeficiency virus (HIV);
- (5) maternal serum alpha-fetoprotein test and ultrasound;
- (6) Rh antibody and glucose screening at 28 weeks gestation;
- (7) mandated newborn screening;

- (8) Rh screening of the infant for maternal RhoGAM treatment; and
- (9) screening for premature labor.

(b) A client must make arrangements to have the results of any of the tests described in paragraph (a) sent to the licensed traditional midwife providing services to the client. The licensed traditional midwife must include these results in the client's record.

Subd. 2. **Written plan.** A licensed traditional midwife must prepare a written plan with each client to ensure continuity of care throughout pregnancy, labor, and delivery. The written plan must incorporate the conditions under which the medical consultation plan, including the transfer of care or transport of the client, may be implemented.

Subd. 3. **Health regulations.** A licensed traditional midwife must comply with all applicable state and municipal requirements regarding public health.

Subd. 4. **Client records.** A licensed traditional midwife must maintain a client record on each client, including:

- (1) a copy of the informed consent form described in section 147D.07;
- (2) evidence of an initial client screening described in this section;
- (3) a copy of the written plan described in subdivision 2;
- (4) a record of prenatal and postpartum care provided to the client at each visit; and
- (5) a detailed record of the labor and delivery process.

Subd. 5. **Data.** All records maintained on each client by a licensed traditional midwife are subject to section 144.335.

### **INFORMED CONSENT (Statute 147D.07)**

Subdivision 1. **General.** Before providing any services to a client, a licensed traditional midwife must:

- (1) advise the client of the information contained in the informed consent form;
- (2) provide the client with an informed consent form; and
- (3) have the form returned with the client's signature attesting that the client understands the consent form and the information contained in the form.

Subd. 2. **Contents.** The informed consent form must be written in language understandable to the client and, at a minimum, must contain the following:

- (1) name, address, telephone number, and license number of the licensed traditional midwife;
- (2) a description of the licensed traditional midwife's education, training, and experience in traditional midwifery;
- (3) the licensed traditional midwife's fees and method of billing;
- (4) the right of the client to file a complaint with the board and the procedures for filing a complaint;
- (5) a description of the licensed traditional midwife's medical consultation plan and the antepartum, intrapartum, and postpartum conditions requiring consultation, transfer of care, or transport to a hospital;
- (6) the scope of care and services to be provided to the client by the licensed traditional midwife;
- (7) the available alternatives to traditional midwifery care;
- (8) a statement indicating that the client's records and any transaction with the licensed traditional midwife are confidential;
- (9) a notice that reads: "We realize that there are risks associated with birth, including the risk of death or disability of either mother or child. We understand that a situation may arise, which requires emergency medical care and that it may not be possible to transport the mother and/or baby to the hospital in time to benefit from such care. We fully accept the outcome and consequences of our decision to have a licensed traditional midwife attend us during pregnancy and at our birth. We realize that our licensed traditional midwife is not licensed to practice medicine. We are not seeking a licensed physician or certified nurse midwife as the primary caregiver for this pregnancy, and we understand that our licensed traditional midwife shall inform us of any observed signs or symptoms of disease, which may require evaluation, care, or treatment by a medical practitioner. We agree that we are totally responsible for obtaining qualified medical assistance for the care of any disease or pathological condition.";
- (10) the right of a client to refuse services unless otherwise provided by law;
- (11) a disclosure of whether the licensed traditional midwife carries malpractice or liability insurance; and
- (12) the client's and licensed traditional midwife's signatures and date of signing.

Subd. 3. **Filing.** The licensed traditional midwife must have a signed informed consent form on file for each client. Upon request, the licensed traditional midwife must provide a copy of the informed consent form to the board.

### **MEDICAL CONSULTATION PLAN.**

An applicant must develop a medical consultation plan, including an emergency plan. The plan must describe guidelines and under what conditions the plan is to be implemented for:

- (1) consultation with a licensed health care provider;
- (2) the transfer of care to a licensed health care provider; and
- (3) immediate transport to a hospital.

The conditions requiring the implementation of the medical consultation plan must meet at a minimum the conditions established by the Minnesota Midwives Guild in the Standards of Care and Certification Guide, the most current edition.

### **CONTINUING EDUCATION**

All licensed traditional midwives must provide evidence every three years of 30 contact hours of board-approved continuing education. At least five contact hours must involve adult cardiopulmonary resuscitation and either infant cardiopulmonary resuscitation or neonatal advanced life support.

### **RENEWAL CYCLE**

Licensure must be renewed annually on or before June 30 of each year. Renewal notices are sent approximately 45 days prior to expiration. It is the traditional midwife's responsibility to keep the Board advised, in writing, of an address change within 30 days. The Board is obligated to mail the renewal application to the address on file. Failure to receive the renewal documents does not relieve traditional midwives of their renewal obligation. In addition to providing evidence of 30 hours continuing education every three years, licensees must submit evidence of an annual peer review and update of the licensed traditional midwife's medical consultation plan.

### **INACTIVE LICENSURE STATUS**

A license may be placed in formal inactive status upon application to the Board. The license may be restored back to active status by completing one hour continuing education for each month of inactive status. If inactive status extends beyond five years, the traditional midwife must achieve a qualifying score on a credentialing examination or complete eight weeks of council-approved supervised practical experience.

The Board will cancel a license for nonrenewal if the license has not been renewed within two annual renewal cycles starting July, 1999. Traditional midwives wishing to practice in Minnesota again once a license has been canceled for nonrenewal must obtain a new license by reapplying and fulfilling all requirements in existence at time of reapplication.

**If any part of this Fact Sheet conflicts with the Minnesota rules or laws, the rules or laws take precedence. It is your responsibility to understand and comply with the regulations. Please call the Board offices if you have any questions.**

# APPLICATION FOR TRADITIONAL MIDWIFERY LICENSE

MINNESOTA BOARD OF MEDICAL PRACTICE

UNIVERSITY PARK PLAZA

2829 UNIVERSITY AVENUE SE, SUITE 500

MINNEAPOLIS, MINNESOTA 55414-3246

(612) 617-2130

Hearing Impaired-Minnesota Relay Service

Metro Area 297-5353

Outside Metro Area 1-800-627-3529



DATE OF APPLICATION:

MONTH	DAY	YEAR

FOR BOARD USE ONLY

APPLICATION #: \_\_\_\_\_

CHECK/RECEIPT #: \_\_\_\_\_

AMT. PAID: \_\_\_\_\_

TEMP PERMIT #: \_\_\_\_\_

BOARD ACTION: \_\_\_\_\_

BOARD DATE: \_\_\_\_\_

LICENSE #: \_\_\_\_\_

FOR BOARD USE ONLY

SOURCE CODE	AMOUNT

## INSTRUCTIONS TO APPLICANT

1. Answer all questions completely, accurately, and legibly and include the appropriate fee or the application will be returned.
2. The name you enter must exactly match the name on your professional diploma, or documentation of formal name change must be submitted.
3. Account for all time from the beginning of high school, whether spent in school, traditional midwifery practice, or otherwise. Date must include Month, Day, and Year. Attach a separate sheet, if necessary.
4. Enter all dates as MONTH/DAY/YEAR.
5. Have attached forms completed and submitted to our office, where applicable.
6. Read the attached laws regarding traditional midwifery licensure.
7. The application fee is not refundable.
8. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently registered by the Board.
9. Incomplete applications will be destroyed after six months of inactivity.

## YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_ GENDER:  MALE  FEMALE MAIDEN NAME: \_\_\_\_\_

SOCIAL SECURITY \_\_\_\_\_ OTHER NAME \_\_\_\_\_

## RECORD OF BIRTH

BIRTHDATE: (Mo/Day/Year) \_\_\_\_\_ CITY OF BIRTH: \_\_\_\_\_ STATE OF BIRTH: \_\_\_\_\_ COUNTRY OF BIRTH: \_\_\_\_\_

## NARM CERTIFICATION (\*)

DATE OF EXAM: (Mo/Day/Year) \_\_\_\_\_ CERTIFICATE #: \_\_\_\_\_ (\*) Attach Notarized Copy of Certification

## BASIS FOR APPLICATION (CHECK ONE)

GENERAL REGISTRATION  RECIPROCITY  TRANSITIONAL



PRELIMINARY EDUCATION					
NAME OF HIGH SCHOOL:	CITY:	STATE OR PROVINCE:	ZIP CODE:	FROM DATE: (Mo/Day/Year)	TO DATE: (Mo/Day/Year)
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	ZIP CODE:	FROM DATE: (Mo/Day/Year)	TO DATE: (Mo/Day/Year)
TYPE OF DEGREE	NAME OF ISSUING SCHOOL:	CITY:	STATE OR PROVINCE:	DATE DEGREE RECEIVED: (Mo/Day/Year)	

TRADITIONAL MIDWIFERY EDUCATION AND TRAINING/APPRENTICESHIP						
INSTITUTION/MIDWIFE	CITY	STATE	ZIP CODE	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	DEGREE/CERT APPRENTICESHIP

OTHER EDUCATION AND TRAINING						
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	DEGREE

STATES/PROVINGES/COUNTRIES IN WHICH YOU ARE OR HAVE BEEN LICENSED OR REGISTERED			
STATE/PROVINCE/COUNTRY	LICENSE # OR REGISTRATION #	DATE ISSUED (Mo/Day/Year)	HOW OBTAINED?*

DRIVERS LICENSE	
STATE:	NUMBER:

\*NARM exam  
Equivalency  
Reciprocity  
Transitional

## ACTIVITIES

LIST BELOW, IN CHRONOLOGICAL ORDER, ALL ACTIVITIES INCLUDING POST-GRADUATE TRAINING, HOSPITAL OR CLINIC AFFILIATIONS, EMPLOYMENT, AND PERIODS OF UNEMPLOYMENT. ACCOUNT FOR ALL TIME SINCE GRADUATION FROM HIGH SCHOOL. ATTACH A CURRICULUM VITAE, IF NECESSARY.

FROM DATE (Month/Year)	TO DATE (Month/Year)	POSITION
NAME OF INSTITUTION:		
STREET ADDRESS:		CITY: STATE: ZIP CODE:
FROM DATE (Month/Year)	TO DATE (Month/Year)	POSITION
NAME OF INSTITUTION:		
STREET ADDRESS:		CITY: STATE: ZIP CODE:
FROM DATE (Month/Year)	TO DATE (Month/Year)	POSITION
NAME OF INSTITUTION:		
STREET ADDRESS:		CITY: STATE: ZIP CODE:
FROM DATE (Month/Year)	TO DATE (Month/Year)	POSITION
NAME OF INSTITUTION:		
STREET ADDRESS:		CITY: STATE: ZIP CODE:
FROM DATE (Month/Year)	TO DATE (Month/Year)	POSITION
NAME OF INSTITUTION:		
STREET ADDRESS:		CITY: STATE: ZIP CODE:
FROM DATE (Month/Year)	TO DATE (Month/Year)	POSITION
NAME OF INSTITUTION:		
STREET ADDRESS:		CITY: STATE: ZIP CODE:
FROM DATE (Month/Year)	TO DATE (Month/Year)	POSITION
NAME OF INSTITUTION:		
STREET ADDRESS:		CITY: STATE: ZIP CODE:
FROM DATE (Month/Year)	TO DATE (Month/Year)	POSITION
NAME OF INSTITUTION:		
STREET ADDRESS:		CITY: STATE: ZIP CODE:

CIRCLE "Y" FOR YES OR "N" FOR NO. ATTACH ADDITIONAL SHEETS TO PROVIDE SUFFICIENT DETAIL. FOR QUESTIONS 1 THROUGH 2 BELOW, THE TERMS "IMPAIRED" AND "LIMITED" INCLUDE BUT ARE NOT LIMITED TO IMPAIRMENTS OR LIMITATIONS RELATED TO PHYSICAL, PSYCHOLOGICAL, OR EMOTIONAL DISORDERS OR CONDITIONS, OR CHEMICAL DEPENDENCY OR CHEMICAL ABUSE. NOTE: IF YOU ARE CURRENTLY PARTICIPATING IN HEALTH PROFESSIONALS SERVICES PROGRAM (HPSP) FOR A CONDITION COVERED BY QUESTIONS 1-4 OR IF YOU DO NOT HAVE THAT CONDITION, YOU MAY LEAVE THE QUESTION UNANSWERED AS TO THAT CONDITION. IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME YOUR APPLICATION IS PENDING, YOU MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

Y	<p>1. Is your cognitive, communicative, or physical capability to engage in the practice of traditional midwifery with reasonable skill and safety impaired or limited in any way? Please describe.</p> <p>Y N 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.</p> <p>Y N 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.</p>
Y	<p>2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice traditional midwifery with reasonable skill and safety? Please describe.</p>
Y	<p>3. Are you engaged in any illegal use of controlled substances, including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.</p> <p>Y N 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.</p> <p>Y N 3b. If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.</p>
Y	<p>4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice traditional midwifery with reasonable skill and safety? If you answer this question "yes", please answer the following:</p> <p>Y N 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?</p> <p>Y N 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?</p> <p>Y N 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice respiratory care with reasonable skill and safety?</p> <p>4d. Please explain. _____</p> <p>4e. Identify your treating physician. _____</p>
Y N	<p>5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.</p>

Y N	6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.
Y N	7. Have you ever been denied a registration/certification/licensure by, or the privilege of taking a traditional midwifery certifying examination or has a conditioned registration/certification/license ever been issued to you by any state board or other licensing authority? If so, give particulars.
Y N	8. Has your registration/certification/license to practice traditional midwifery in any state or country ever been voluntarily or involuntarily (i.e. by State Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a State Board or other licensing authority? If so, give particulars.
Y N	9. Have you ever been notified of any investigations by any state board, traditional midwifery society, certifying authority or any health facility of any complaints against you relative to the practice of traditional midwifery, or have you ever been reprimanded or censured by any traditional midwifery society or licensing board? If so, give particulars.
Y N	10. Have you ever had any malpractice settlements made on your behalf or do you have any malpractice lawsuits pending? If so, give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents).
Y N	11. Have you ever been denied, restricted, or revoked staff affiliations with a hospital, nursing home, clinic, or other health care facility? If so, give particulars.
Y N	12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Y N	13. Have there ever been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed.

AFFIDAVIT OF APPLICANT

STATE OF: \_\_\_\_\_

COUNTY OF: \_\_\_\_\_

ATTACH RECENT PHOTO HERE

bust photo (not full length)

PHOTO MUST BE NOTARIZED  
AS A TRUE LIKENESS

I, \_\_\_\_\_, swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes and rules of Minnesota; that I am the person named in the diploma and certificate which accompany this application; that I am the lawful holder of said diploma and certificate; that said diploma and certificate were procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to traditional midwifery in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Signature of Applicant

**RIGHTS OF SUBJECTS OF DATA**

This information is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations when appropriate. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently registered by the Board.



# MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246

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MN Relay Service for Hearing Impaired (800) 627-3529

## ADDENDUM TO APPLICATION

### 1. BUSINESS ADDRESS

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I certify that I am not currently in workforce related to my practice, and I don't have a business address related to my practice.

### 2. MILITARY STATUS

Are you or your spouse returning from active military duty (discharged less than 6 months ago) or still in active military duty?

No  Yes. If discharged, please provide discharge date: \_\_\_\_\_

### 3. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has been convicted of a felony or gross misdemeanor occurring on or after July 1, 2013 in any state or jurisdiction. This information shall be posted for new licensees issued a license on or after July 1, 2013 and for current licensees upon license renewal occurring on or after July 1, 2013. This information is public and you are required to submit it for application purposes. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.

If you have more than one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): \_\_\_\_\_

Conviction Type (Check one):  Felony  Gross misdemeanor

Crime Description: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Country: \_\_\_\_\_

Sentence: \_\_\_\_\_

I certify that I have had no convictions on or after July, 1, 2013

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



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## TRADITIONAL MIDWIFE VERIFICATION OF CERTIFIED PROFESSIONAL MIDWIFE (CPM) CERTIFICATION

This form is for verification certified professional midwife (CPM) certification. The form must be mailed directly by North American Registry of Midwives (NARM) to the **Minnesota Board of Medical Practice**. Any fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name \_\_\_\_\_ SS# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

NARM COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: \_\_\_\_\_  
(Name of traditional midwife)

WAS ISSUED A CERTIFICATE ON: \_\_\_\_\_  
(Month, Day, Year)

BY THE NORTH AMERICAN REGISTRY OF MIDWIVES: \_\_\_\_\_  
(Month, Day, Year)

EXPIRATION DATE IS: \_\_\_\_\_  
(Month, Day, Year)

ANY DISCIPLINARY ACTION AGAINST CERTIFICATE HOLDER?\*

ANY COMPLAINTS PENDING AGAINST CERTIFICATE HOLDER?\*

SEAL\*\*

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Phone # \_\_\_\_\_

\*If yes, attach letter of explanation on letterhead.  
\*\*If there is no seal, attach letter of explanation on letterhead.



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## CERTIFICATION OF TRADITIONAL MIDWIFERY EDUCATION

This form is for certification of traditional midwifery education for general registration and reciprocity applicants and must be completed and mailed by the facility directly to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to this Board.

Print Name \_\_\_\_\_ SS# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Date of Degree/ Certificate (Month, Day, Year) \_\_\_\_\_ Degree/Certificate Received \_\_\_\_\_

\*\*\*\*\*  
THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: \_\_\_\_\_  
(Name of Applicant)

MATRICULATED IN : \_\_\_\_\_  
(Name of School)

A MEAC ACCREDITED PROGRAM LOCATED AT: \_\_\_\_\_  
(Location of School)

AND RECEIVED A DIPLOMA CONFERRING: \_\_\_\_\_  
(Degree of Certificate)

ON: \_\_\_\_\_  
(Month, Day, Year)

ANY DISCIPLINARY ACTION? Yes\* \_\_\_\_\_ No \_\_\_\_\_

ANY DEROGATORY INFORMATION ON FILE? Yes\* \_\_\_\_\_ No \_\_\_\_\_

School

Seal\*\*

President, Secretary, Dean, Registrar:

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Phone Number \_\_\_\_\_

\*Please attach letter of explanation.

\*\*If there is no school seal, attach letter of explanation on letterhead.





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## TRADITIONAL MIDWIFE VERIFICATION OF LICENSURE/REGISTRATION/CERTIFICATION

This form is for verification of all traditional midwife and other health care professional licenses or registrations from every jurisdiction issuing any type of license, registration, or certification including training, and temporary permit even if license is not current. Each Board completing the form must mail directly to the **Minnesota Board of Medical Practice**. Any fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name \_\_\_\_\_ SS# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*  
THE JURISDICTION COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: \_\_\_\_\_  
(Name of Lay Midwife)

DATE OF BIRTH: \_\_\_\_\_  
(Month, Day, Year)

WAS ISSUED LICENSE NUMBER: \_\_\_\_\_

BY: \_\_\_\_\_ ON: \_\_\_\_\_  
(State) (Month, Day, Year)

EXPIRATION DATE IS: \_\_\_\_\_  
(Month, Day, Year)

ISSUED ON THE BASIS OF: \_\_\_\_\_  
(Exam/certificate)

DISCIPLINARY ACTION EVER INITIATED, PENDING, OR INVOKED\*: \_\_\_\_\_  
(Yes/No)

EVER VOLUNTARILY RELINQUISHED LICENSE\*: \_\_\_\_\_  
(Yes/No)

SEAL\*\*

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_  
(Day, Month, Year)

\*If yes, please attach letter of explanation.  
\*\*If there is no seal, attach letter of explanation on letterhead.



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## TRADITIONAL MIDWIFE TEMPORARY PERMIT APPLICATION

A temporary permit is available for traditional midwives who have applied for permanent licensure and have complied with all requirements and wish to practice prior to the next regularly scheduled Board meeting. Upon request, a temporary permit will be issued after eligibility for licensure has been established and the credentialing and verification process has been completed. This process may take several weeks. The Board may, at its discretion, issue a temporary permit under the above conditions. A temporary permit is valid only until the next Board meeting at which your application would be considered.

Applicants requesting a temporary permit must complete this form and submit a non-refundable \$75 fee in U.S. currency. Please make checks payable to the **Minnesota Board of Medical Practice**.

**NAME:** (Please Print) \_\_\_\_\_

### TEMPORARY PERMIT WILL BE USED AT THE FOLLOWING PROPOSED PRACTICE LOCATION:

\_\_\_\_\_  
(Name of Location)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zipcode)

**PROFESSIONAL TELEPHONE NUMBER:** (Including Area Code) \_\_\_\_\_

**ANTICIPATED DATE OF COMMENCING PRACTICE  
AT PROPOSED PRACTICE LOCATION:** \_\_\_\_\_

**MAILING ADDRESS FOR TEMPORARY PERMIT:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## TRADITIONAL MIDWIFE RECOMMENDATION FORM

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two physicians, lay midwives or other health care professional who is knowledgeable regarding applicant's professional conduct and character during the last five years and is not a family member. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

THE PERSON SERVING AS A REFERENCE COMPLETES THE FOLLOWING INFORMATION:

**RECOMMENDATION FOR:** \_\_\_\_\_  
(Print Name of Applicant)

1. How long have you known the applicant? \_\_\_\_\_

2. What has been the nature of your relationship with the applicant? \_\_\_\_\_  
\_\_\_\_\_

3. How would you characterize the moral and professional conduct of the applicant? \_\_\_\_\_  
\_\_\_\_\_

4. Would you recommend the applicant for approval of licensure for the practice of lay midwifery?  
\_\_\_\_\_

5. Circle the word(s) which best describes this applicant...

- |           |                       |   |
|-----------|-----------------------|---|
| Marginal* | Fully Meets Standards | A. Clinical skills                        |
| Yes*      | No                    | B. Any indication of chemical dependency? |

Completed By:

Print Name \_\_\_\_\_ Health Profession \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

\*Please attach letter of explanation.



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Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

THE PERSON SERVING AS A REFERENCE COMPLETES THE FOLLOWING INFORMATION:

**RECOMMENDATION FOR:** \_\_\_\_\_  
(Print Name of Applicant)

1. How long have you known the applicant? \_\_\_\_\_

2. What has been the nature of your relationship with the applicant? \_\_\_\_\_

\_\_\_\_\_

3. How would you characterize the moral and professional conduct of the applicant? \_\_\_\_\_

\_\_\_\_\_

4. Would you recommend the applicant for approval of licensure for the practice of lay midwifery? \_\_\_\_\_

\_\_\_\_\_

5. Circle the word(s) which best describes this applicant...

- |           |                       |   |
|-----------|-----------------------|---|
| Marginal* | Fully Meets Standards | A. Clinical skills                        |
| Yes*      | No                    | B. Any indication of chemical dependency? |

Completed By:

Print Name \_\_\_\_\_ Health Profession \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

\*Please attach letter of explanation.



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## Medical Consultation Plan

To be eligible for licensure as a traditional midwife, *Minn. Stat. 147D.11* requires that an applicant develop a medical consultation plan, including an emergency plan. The plan must describe guidelines and under what conditions the plan is to be implemented for:

- (1) consultation with a licensed health care provider;
- (2) the transfer of care to a licensed health care provider; and
- (3) immediate transport to a hospital.

The conditions requiring the implementation of the medical consultation plan must meet at a minimum the conditions established by the Minnesota Midwives Guild in the Standards of Care and Certification Guide, the most current edition.

To simplify the application process and ensure that the Medical Consultation Plan statutory requirements are met, a Medical Consultation Plan form including B,C,E appendices have been included in the application packet.

I certify that I will use the Medical Consultation Plan as provided in my application packet including the most current edition Minnesota Midwives Guild in the Standards of Care and Certification Guide.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## MEDICAL CONSULTATION PLAN

Client Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Day Phone # \_\_\_\_\_ Eve Phone # \_\_\_\_\_ LMP \_\_\_\_\_ EDD \_\_\_\_\_

Insurance Plan \_\_\_\_\_ SS or ID# \_\_\_\_\_

Medical Provider \_\_\_\_\_ Office Phone # \_\_\_\_\_

Baby's Medical Provider \_\_\_\_\_ Office Phone # \_\_\_\_\_

Hospital \_\_\_\_\_ Hospital Phone # \_\_\_\_\_

Date document given \_\_\_\_\_ Date document returned \_\_\_\_\_

This plan has been approved by (name of practice): _____ Date: _____ Signature: _____
--

This plan has not been approved by (name of practice): _____ Date: _____ Signature: _____ Reasons: _____
--

All midwives licensed by the State of Minnesota are required by law to have an "emergency transport plan" for every woman under their care. The law in itself does not define what an "emergency" is. However, an example is when a client would no longer be able to continue with out of hospital birth plans and would be needing the expertise of a medical provider. As part of the transport plan, when the situation may be life-threatening to the mother or baby, call 911. Those types of situations/conditions may be, but are not limited to: suspected or known placental abruption, cord prolapse, hemorrhage not responding to treatment, suspected severe fetal distress determined by fetal heart tones, cardiac arrest, eclampsia/maternal convulsions, APGAR or 7 or less at 5 minutes and not improving, etc.

Most situations where a client needs to be at the hospital will occur intrapartum and immediate postpartum. Conditions and situations may be: failure to progress, maternal exhaustion or dehydration, prolonged rupture of membranes, infection; shown as temperature above 100.8, shaking chills, elevated pulse, foul smelling amniotic fluid, maternal respiratory distress, signs and symptoms of pre-eclampsia, transverse lie, unforesen breech presentation; excessive painless vaginal bleeding, maternal shock, moderate to heavy meconium; retained or suspected retained placental fragments, hemorrhage not responding to treatment, persistent uterine atony, mother unable to void within 6 hours of birth, chest pain or cardiac irregularities, laceration requiring medical attention. For the infant: signs of suspected fetal distress, suspected or known MAS in infant, apnea, irregular respiratory efforts: persistent grunting, retractions or nasal flaring, abnormal color: persistent pale, cyanotic or gray color, abnormal cry: weak or high pitched tremors, hyperactivity or seizures, generalized edema, obvious or suspected birth injury, cannot maintain body temperature, lethargy or inability to feed well, projectile vomiting, temperature of 100.8 or higher, and any other situation or condition that the midwife feels needs immediate attention or the mother desires transport to the hospital.

Medical Consultation Plan B,C,E appendices

# Appendix B

## Contraindications for Homebirth Based on Conditions Identified During Prenatal Care

At any point during prenatal care, conditions may be identified that show a contraindication for home birth. Except in emergency situations, a midwife should not assume or continue to share responsibility for prenatal and / or birth attendance for women with the following conditions:

1. Failure to document adequate prenatal care:
  - (α) Prenatal lab work; Rh antibody screening, Rubella titer, VDRL, Blood Group and Type, Hemoglobin, Hepatitis, GBS screening (or signed waiver)
  - (β) Must have initiated prenatal care by 28<sup>th</sup> week gestation.
2. Rubella during the first trimester
3. Primary outbreak of genital herpes
4. Persistent pregnancy induced hypertension
5. Pre-eclampsia
6. Convulsions
7. Central Placenta Previa
8. Placental abruption or signs indicative of placental abruption
9. Placenta located over previous uterine scar
10. Suspected or diagnosed congenital fetal anomaly that may require immediate medical care after birth
11. Hemoglobin less than 9 at 36 weeks
12. Premature labor: 36 weeks or less
13. Serious viral/bacterial infection at term
14. SGA
15. Suspected IUGR
16. Unresolved fearfulness regarding home birth or midwife care, or otherwise desires transfer of care
17. Any other condition or situation which may preclude the possibility of a healthy birth, at the midwife's discretion

# Appendix C

## Situations / Conditions Requiring Documented Medical Consultation

During the course of midwifery care, conditions may arise that need special expertise.

Conditions which require additional help or consultation include:

1. Vaginal or urinary tract infection unresolved
2. Suspected inappropriate gestational size for more than 2 consecutive prenatals
3. Suspected IUGR
4. Suspected multiple gestation
5. Unresolved anemia (HGB 10 or less)
6. Observed maternal cardiac irregularities
7. Kidney infection, shown as fever and shaking, chills, low back pain, hematuria, loss of appetite, nausea and vomiting, cystitis, urinary frequency, and dysuria due to cystitis, and supra pubic pain
8. Elevated blood glucose levels unresponsive to dietary and exercise management
9. Abnormal vaginal bleeding before onset of labor
10. Maternal leg pain, persistent and unresolved
11. FHT's not heard by 24 weeks gestation or at any later point in the pregnancy
12. Abnormal fetal heart tones detected prenatally
13. Marked decrease or cessation of fetal movement
14. Suspected malpresentation or abnormal presentation at 36 weeks gestation or later
15. Suspected or known postdates pregnancy beyond 42 weeks gestation with biophysical score of 6 or less
16. Active pushing longer than 4 hours on first time mother with no descent or 3 hours on subsequent births with no descent
17. Indications that the baby has died in utero
18. Indications of infection in the immediate postpartum
19. Medical significant newborn anomaly
20. Newborn temperature of 100.8 or greater for 2 consecutive readings in 1 hour
21. Newborn cardiac irregularity
22. Signs of prematurity, dysmaturity, or postmaturity
23. Birth weight of less than 5 lbs.
24. 2 vessel cord
25. Jaundice within the first 24 hours
26. Failure to pass meconium or urine within the first 24 hours
27. Signs of umbilical infection
28. Unresolved bleeding in excess of normal lochia flow
29. Subinvolution
30. Failure of laceration / episiotomy site to heal properly with signs of infection or breakdown
31. Signs of serious postpartum depression or psychosis
32. Tremors, hyperactivity or seizures
33. The pregnant woman or midwife wishes such care or consultation



# Appendix E

## Situations / Conditions Requiring Hospital Transport

1. Cardiac arrest
2. Chest pain or cardiac irregularities
3. Signs of postpartum pre - eclampsia, or eclampsia
4. Eclampsia / maternal convulsions
5. Maternal respiratory distress
6. Unresolved signs of fetal distress
7. Cord prolapse
8. Transverse lie (in labor)
9. Heavy meconium staining and deviations in FHT's (if the expected time of birth is greater / longer than the projected transport time)
10. Foul smelling amniotic fluid
11. Infection: maternal temp. above 100.8, shaking, chills, elevated pulse
12. Excessive antepartum and intrapartum painless vaginal bleeding
13. Placental abruption
14. Suspended placenta accreta
15. Hemorrhage not responsive to treatment
16. Unresolved maternal shock
17. Apnea
18. Persistent uterine atony
19. Uterine inversion
20. Laceration requiring medical attention
21. Suspected meconium aspiration
22. Apgar score of 6 or less at 5 minutes and not improving
23. Unresolved respiratory distress of newborn
24. Abnormal color in newborn: persistent central cyanosis
25. Unresolved abnormal cry in newborn: weak, or high pitched
26. Obvious or suspected birth injury
27. Newborn cannot maintain body temperature
28. Projectile vomiting
29. Inability of newborn to feed well due to lethargy
30. Newborn temperature of 100.8 two consecutive readings ten minutes apart
31. Birthing woman desires transport for herself and / or her newborn

Every effort must be made to transport in good condition. The midwife will accompany the mother and / or baby to the hospital if hospitalization is necessary. If possible, the midwife may remain with the mother and / or baby to ascertain outcome and provide continuity of care. A transport form should accompany the mother and / or baby to the hospital.