

INSTRUCTIONS FOR COMPLETING A LICENSED MIDWIFE APPLICATION
(This form has been designed to be used as a checklist for submitted required documentation.)

The applicant is responsible for forwarding all required forms to the appropriate institutions, states, and other agencies.

- Licensure application:** Follow the instructions provided on the application.
- Licensure fee:** A check or money order for **\$277.00**, made payable to the "Treasurer of Virginia".

***Please note: Application and fee must be submitted together. If received separately, they will be returned.**

- Complete Form A (**Claims History**) - If you answered yes to question #10 on page two of the application. This documentation **may** be faxed.
- Jurisdiction Clearance (Form C)** - Forward Form C to all jurisdictions in which you have been licensed, certified or registered. This documentation **may** be faxed directly from the jurisdiction.
- Certification of credentials from NARM** - Certification should be requested from the North American Registry of Midwives, P.O. Box 7703, Little Rock, AR 72217-7703, 1-888-353-7089, or testing@narm.org, or fax, 404-521-4052. Verification of certification **may not** be faxed.

Please note:

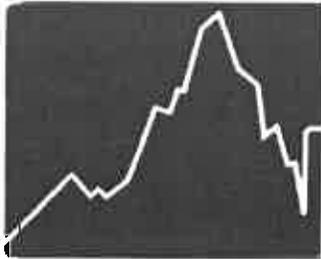
*Please be aware that consistent with Virginia law and the mission of the Department of Health Professions, addresses on file with the Board of Medicine are made available to the public. This has been the policy and the practice of the Commonwealth for many years. However, with the application of new technology, which makes this information more accessible, there has been growing concern of those licensees who supply their residence address for mailing purposes. This notice is to reiterate that the Board of Medicine maintains only one address for each licensee and will allow the address of record to be a Post Office Box or practice location.

*Applications not completed within 12 months may be purged without notice from the board. The application fee for applications not completed within 12 months will be forfeited.

*Additional information may be requested after review by board representatives.

*Application fees are non-refundable.

*Contact: Beula Archer at beula.archer@dhp.virginia.gov
Fax: 804-527-4426



**Department of Health Professions
Commonwealth of Virginia**

**Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463**

**Phone: (804) 367- 4600
FAX: 804-527-4426
email: medbd@dhp.virginia.gov**

**Application for a License to Practice
as a Licensed Midwife**

I hereby make application for a license to practice as a Midwife in the Commonwealth of Virginia and submit the following statements:

Last		First		Middle	
Street Address		City/State		Zip Code	
Date of Birth ____/____/____	Place of Birth	Social Security/VA Control #		Maiden Name if Applicable	

Please accompany with this application a check or money order made payable to the Treasurer of Virginia in the required amount. If payment does not accompany the application, the application **will** be returned. Please submit address changes in writing immediately.

*In accordance with §54.1-116 in the Code of Virginia, you are required to submit your Social Security number/Control number (issued by the Virginia Department of Motor Vehicles). This number will be used by the Department of Health Professions for identification purposes only and will not be disclosed for any other purposes except as mandated by law. Federal and State law requires that this number be shared with other state agencies for child support enforcement activities. **Failure to disclose this number will result in the denial of a license to practice in the Commonwealth of Virginia.**

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY: _____

DATE: _____

Applicant #	Check #	Class #	Fee \$277.00

1. Please provide a telephone number where you can be reached during the day.

Home #:	Work #:	Email Address:

The following questions must be answered in order for your application to be considered complete. If any of the following questions (#5-12) is answered yes, please provide supporting documentation. Letters may be submitted by your attorney regarding malpractice suits (or you may complete and submit Form A yourself.)

2. List all jurisdictions in which you have been issued a license, certificate, or registration to practice as a midwife. Include the number and date issued of all active, inactive or expired licenses.

Jurisdiction	Number Issued	Active/Inactive/Expired

3. Are you registered with the North American Registry of Midwives? Yes No
4. Have you ever been denied the privilege of taking a midwifery examination for licensure, certification or registration? Yes No
5. Have you ever been denied a midwifery license, certificate, or registration? Yes No
6. Have you ever been convicted of a violation to any federal, state or local statute regulation or ordinance, or entered into any plea agreement relating to a felony or, misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) Yes No
7. Have you ever been denied privileges or voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or requested to withdraw from the staff of any professional school, or any other facility. Yes No
8. Have you ever had any of the following disciplinary actions taken against your license or certification to practice as a midwife or any such actions pending? (a) suspension/revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored Yes No
9. Have you ever had any membership in a state or local professional society revoked, suspended, or sanctioned? Yes No
10. Have you had any malpractice suits brought against you in the last ten (10) years? If so, how many? _____
(Provide details on Form A) Yes No
11. Have you been physically or emotionally dependent upon the use of alcohol/drugs or treated by, consulted with, or been under the care of a professional for any substance abuse within the last two years? If so, please provide a letter from the treating professional. Yes No
12. Do you have a physical disease, mental disorder, or any condition, which could affect your performance of professional duties? If so, provide a letter from your treating professional to include diagnosis, treatment, prognosis and fitness to practice. Yes No
13. Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? Yes No

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of individuals and groups listed above, any information, which is material to me and my application.

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 practice as a licensed midwife in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of my profession which are available on www.dhp.virginia.gov, and I fully understand that funds submitted as part of the application process shall not be refunded.

Signature of Applicant