



## Midwife-in-Training Application Packet

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### Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

### In order to process your request:

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
P.O. Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Midwifery Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877

**Contact us:**

360-236-4700

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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the forms required.

**Application Fee. This fee is non-refundable.** You can check the online [fee page](#) for current fees.

**1. Demographic Information:**

**Social Security Number:** You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have them.

**National Provider Identifier Number (NPI):** The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

**Legal Name:** List your full name: first, middle, and last.

**Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the month, day, and year of your birth.

**Birth place:** Provide the city, state, and country where you were born.

**Address:** List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county and country. This will be your permanent address with Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax, and Cell Numbers:** Enter your phone, fax, and cell numbers, if you have one.

**Email:** Enter your email address, if you have one.

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

**2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

**3. Education and Training:**

List in date order your educational preparation and post-graduate training. Attach additional pages if you need more space.

**4. Experience:**

List in date order all of your professional experience and practice from date of graduation from professional college. Attach additional pages if you need more space.

**5. Other License, Certification, or Registration:**

List all states where credentials are or were held. Attach additional pages if you need more space.

**6. AIDS Education and Training Attestation:**

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in [WAC 246-12-270](#).

**7. Applicant’s Attestation:**

You must sign and date this for us to process the application.

## **License Requirements**

### **Applicants must submit the following:**

- A completed midwife-in-training application form as described on the application instructions checklist.
- Proof of completion of high school or equivalent. This may be verified by your midwifery program.
- If you hold a healthcare license in any state, your health care license certification must be submitted directly from each state. [Form enclosed](#).

## **Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington**

Under state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please submit the required military documentation with your application for licensure found on your [profession applications and forms page](#).

Date  
Stamp  
Here

Revenue 0252130000

## Midwife-in-Training Application

Please print clearly in blue or black ink. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)	<b>Place of birth</b>		
	City	State	Country

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
--------------------------	------------------------	-------------------------

Email address

Mailing address if different from above address of record

City	State	Zip Code	County
------	-------	----------	--------

Country

**Note:** The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)?  Yes  No  
 If yes, list name(s):

Will documents be received in another name?  Yes  No  
 If yes, list name(s):

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

## 2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs?.....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? .....

## 3. Education and Training

List in date order all of your educational preparation and post-graduate training. Attach additional pages if you need more space.

Attendance		Name and address of institute, or place of practice	Degree Earned
Start mm/yyyy	End mm/yyyy		

## 4. Experience

List in date order, most recent to later, all of your professional experience. Attach additional pages if you need more space.

Attendance		Name and address of institute, place of practice	Type of experience or specialty
Start mm/yyyy	End mm/yyyy		

## 5. Other License, Certification or Registration

List all states where credentials are or were held. Attach additional pages if you need more space.

State	Profession	License	License Type	Method of License	Currently Active?
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes

## 6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. That includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

## 7. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state  
(Print applicant name clearly)  
of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ at \_\_\_\_\_  
(mm/dd/yyyy) (city/state)

By: \_\_\_\_\_  
(Original signature of applicant)

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Washington State Department of

**Health**

Midwifery Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877  
360-236-4700

## Out-of-State Credential Verification

### To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered. Instruct them to return the form directly to the address listed above. Licensing agencies normally charge a fee to verify a credential, please check in advance to help expedite this process. This form may be duplicated.

Name: Last	First	Middle
Mailing Address		
City	State	Zip Code
Any other names used:		
Credential Number	Date Issued	

Have the licensing agency return this completed form to the address listed above.

**(To be Completed by the Regulatory Agency)**

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of credential holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by:	Date:	Score:
<input type="checkbox"/> Written Examination		
Name of examination:		
<input type="checkbox"/> Other Examination	Date:	Score:
Name of examination:		
Is credential current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration Date:	
Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "no", please attach explanation.		
Has this credential ever been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Surrendered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Reinstated? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "yes", please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

(SEAL)

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Title:

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

## **Midwife-in-Training Permit Prospectus and Academic Plan**

Please print clearly in blue or black ink to ensure appropriate review of your prospectus.

Carefully read the prospectus form. Three options are listed under heading B. There are seven academic areas listed on pages two through four. You must select option number one, two, or three for each academic area.

- If you select option one, please check the box labeled **Previously Studied** and include transcripts or proof of study.
- If you select option two, please check the box labeled Challenge Examination, and send proof of taking a challenge examination for that subject.
- If you select option three, list your learning objectives and learning activities in the appropriate boxes. Learning objectives are statements of **what** you will learn or study, and learning activities are statements of **how** you will learn. Please include a schedule for your learning activities. Attach additional pages if you need more space.
- Complete C and D on page number five.
- Please give the Preceptor Vitae and Agreement form to your preceptor. The preceptor must fill in this form, typed or printed clearly in blue or black ink, before it is sent to the address listed above. Be sure the preceptor signs the form on the reverse side.

### **Examination:**

Upon completion of the Midwife-in-Training program, you must submit the following before you will be scheduled for the licensure examination:

- Complete application for examination with the appropriate [fees](#).

### **When the following is submitted:**

- Completed application and [fee](#);
- Prospectus;
- Preceptor agreement;

The information will be reviewed. Upon approval a permit will be sent to you. This permit is valid for care undertaken only when your preceptor is giving on site supervision.

# Midwife-in-Training Prospectus

Proposed Length of program: \_\_\_\_\_

A. Plan for completion of academic subjects required in [RCW 18.50.040\(2\)\(b\)](#).

B. Listed on the following pages are the subject areas required by law. For each area indicate:

1. The subject has been studied in formal class format, and transcript evidence will be provided.

OR

2. It is your intent to demonstrate knowledge and competence through a challenge exam at the onset of this program.

OR

3. The subject will be studied through learning activities of the Midwife-in-Training program. For each of these areas, list learning objectives and learning activities, including readings and written assignments.

## Midwife-in-Training Academic Plan

Academic Area	Previously Studied	Learning Objectives	Learning Activities
1. Obstetrics, Obstetrical pharmacology, and medical/legal aspects.			
2. Female reproductive anatomy and physiology, and gynecology.			
3. Neonatal pediatrics, genetics and embryology.			
4. Nutrition during pregnancy and lactation, and breast feeding.			

Academic Area	Previously Studied	Learning Objectives	Learning Activities
5. Childbirth education, family planning, community care, and epidemiology.			
6. Basic and behavioral sciences.			
7. Nursing Skills			



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## Midwife-in-Training Evidence of Birth Observations

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

Please list name and address of mother, date of birth, and initials of attendant in charge during the birth.  
Attach affidavit for each birth listed.

Name	Address	Birthdate	Attendant Initials
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
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18.			
19.			
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21.			
22.			
23.			
24.			
25.			

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## Midwife-in-Training Preceptor Vitae and Agreement

Name	Last	First	Middle
Address			
City		State	Zip Code
Phone (enter 10 digit #)			

Practice site/office:
Washington license type and number:
Years in clinical practice (obstetric or midwifery) (exclude any significant inactive periods since licensure):
Number of births attended:
List activities and studies which demonstrate professional growth and development beyond basic licensure (attach additional pages if you need more space.)
Membership in professional associations or organizations:

Attach two professional references from medical professionals which address:

- Length of time writer has been associated with preceptor candidate and in what capacity
- Preceptor candidate's demonstrated ability to provide safe, quality care

**Statement:**

I am familiar with the requirements of WAC 246-834-220 and agree to fulfill the midwife preceptor role as stated therein.

I will adequately supervise the education and activities of \_\_\_\_\_  
name of applicant

including supervision of the trainee in managing care in the prenatal, intrapartum, and early postpartum period. I also agree to submit checklists of skills and experiences and quarterly progress reports.

\_\_\_\_\_  
Signature

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

## **RCW/WAC and Online Website Links**

### **RCW/WAC Links**

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Midwifery Laws, RCW 18.50](#)

[Midwifery Rules, WAC 246-834](#)

### **On-Line**

[AIDS Training Resources, Reference Page](#)

[Midwifery Advisory Committee, Web Page](#)

[Washington State Midwifery Association, http://www.washingtonmidwives.org/](http://www.washingtonmidwives.org/)

[North American Registry of Midwives \(NARM\), http://www.narm.org](http://www.narm.org)