



Midwifery License Application Packet

Contents:

- 1. 679-135...Contents List/SSN Information/Mailing Information.....1 page
- 2. 679-133...Application Instructions Checklist.....2 pages
- 3. 679-002...License Requirements.....3 pages
- 4. 679-001 ...Midwifery License Application5 pages
- 5. 679-132...Out-of-State Credential Verification.....2 pages
- 6. 679-121 ...Data Submission Attestation and Current Plan for Consultation,
Emergency Transfer and Transport.....2 pages
- 7. 679-153...Washington Specific Review of Legend Drugs and Devices.....2 pages
- 8. 679-118 ...Disability Accommodation Request.....1 page
- 9. 679-130 ...Required Midwifery Courses2 pages
- 10. RCW/WAC Links and Online Website Links1 page

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 ink. It is your responsibility to submit the correct forms required.

Select one: Graduate from an approved school
Out-of-State / International School
Certified Professional Midwife (CPM)
Certified Professional Midwife (CPM) Trainee

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

Select if the following applies:
Spouse or Registered Domestic Partner of Military Personnel

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. Examination Information:

If you have taken and passed the North American Registry of Midwives (NARM) examination you must have verification from the examination company sent directly to the Department of Health.

6. Other License, Certification, or Registration:

List all states where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional pages if you need more space.

7. 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](#). If AIDS education was included in your professional education or training, an additional course is not required.

8. Applicant’s Attestation:

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

License Requirements

If you graduated from a Washington State accredited program (Bastyr University or National College of Natural Medicine) you must submit the following:

- The completed application and [fee](#).
- [Washington State Midwifery Jurisprudence Examination](#).
- If you hold a health care license in any state, your health care license certification must be submitted directly from each state. [Form enclosed](#).
- Transcripts sent directly from your school that shows you have received a Midwifery Certificate or degree and course curriculum. This includes verification of all classroom subjects and clinical training.
- Verification of successfully passing the national examination offered by the North American Registry of Midwives (NARM)
- Current plan for consultation, emergency transfer, and transport. [Form enclosed](#).
- Documentation of attendance at 100 births as required in [WAC 246-834-140](#).

If you have attended an international school or a school that is not accredited by Washington State, you must submit the following:

- The completed application and [fee](#).
- [Washington State Midwifery Jurisprudence Examination](#)
- If you hold a health care license in any state, your health care license certification must be submitted directly from each state. [Form enclosed](#).
- Documentation sent directly from the midwifery school which shows course curriculum. If the transcripts are in a foreign language, they must be transcribed.
- International applicants licensed outside of USA must have documentation sent directly from the country the midwifery certificate was obtained.
- Course content form for required midwifery courses. This should be submitted directly from your midwifery program. [Form enclosed](#).
 - Additional documentation may be requested, as needed, to verify that all required course content and/or clinical requirements have been met.
- Verification of successfully passing the national examination offered by the North American Registry of Midwives (NARM)
- Documentation of attendance at 100 births as required in [WAC 246-834-065](#).

If you have a current Certified Professional Midwife (CPM) and are applying by CPM you must submit the following as required in [WAC 246-834-066](#).

- The completed application and [fee](#).
 - Proof of current CPM certification sent directly to the department.
 - [Washington State Midwifery Jurisprudence Examination](#)
 - Documentation of attendance at 100 births as required in [WAC 246-834-066](#).*
 - Proof of prenatal and postpartum care examinations [WAC 246-834-066](#).*
 - A signed legend drugs and devices form. [Form enclosed](#). *
 - Successful completion of courses on epidemiology and obstetric pharmacology.*
 - Verification of successfully passing the national examination offered by the North American Registry of Midwives (NARM).
 - If you hold a health care license in any state, your health care license certification must be submitted directly from each state. [Form enclosed](#).
 - Current plan for consultation, emergency transfer, and transport.
- * If you have not met these requirements you may qualify for a CPM trainee permit to complete the requirements listed in [WAC 246-834-066](#).

If you are applying for a CPM trainee permit you must submit the following:

- The completed application and [fee](#).
- Proof of current CPM certification sent directly to the department.
- Verification of successfully passing the national examination offered by the North American Registry of Midwives (NARM).
- Current plan for consultation, emergency transfer, and transport.

Midwifery Examination:

North American Registry of Midwives (NARM)

The Department of Health has adopted the national examination offered by the North American Registry of Midwives (NARM) for state licensure. A Washington State specific examination is also required.

Applicants for the NARM examination must also apply directly to NARM using the NARM Agency Candidate Application Form supplied by the department. The agency candidate form will be mailed to each candidate once the department has determined that the candidate is eligible for license in Washington State. The NARM fee must be sent directly to NARM with the agency candidate Form. This fee is in addition to the fees paid to the Department of Health.

Applicants who successfully pass the NARM examination must ensure that verification is sent directly to the Department of Health from NARM.

Washington State Add-On Examination

All applicants will be required to pass the Washington State Add-On Examination. Once all license requirements have been met for full licensure you will be notified of approval to sit for the examination.

Applicants with disabilities who wish to request special accommodations must do so when submitting their application. [Form enclosed](#).

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
 - A copy of your marriage certificate to show proof of marriage; or
 - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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Date
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Midwifery License Application

Select one: Graduate from an approved school Out-of-State / International School
 Certified Professional Midwife (CPM) Trainee Certified Professional Midwife (CPM)

Select if the following applies: Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	National Provider Identifier Number (NPI) (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)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County
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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. If you need more space, attach a sheet of paper.

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

4. Experience

List in date order all of your professional experience. If you need more space, attach a sheet of paper.

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

5. Examination Information

Have you taken and successfully passed the North American Registry of Midwives (NARM) examination?

Yes No

Are you requesting approval to sit for the North American Registry of Midwives (NARM) examination?

Yes No

Note: Prior to licensure you must take and pass the North American Registry of Midwives (NARM) examination.

6. Other License, Certification, Registration

List all states where credentials are or were held. List credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. If you need more space, attach a sheet of paper.

State	Profession	License	License Type	Method of License	Currently in force
					<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

7. 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.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's Initials	Date

8. 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 have read all laws and rules related to my profession.

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 this form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. The regulatory agency will complete page two.

Name: Last			First			Middle		
Mailing Address								
City						State		Zip Code
Phone (enter 10 digit #)					Cell (enter 10 digit #)			
Email address								
Any other names used:								
Type of license(s) you hold or have held in other state(s):								
Washington State healthcare credential type you are applying for:								
Washington State healthcare credential number (if available):						Date Issued		

Have the licensing agency complete page two and return this form to the address listed above.
If you have any questions, please call 360-236-4700.

This form may be duplicated.

(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 license, certification, or registration holder:		
Authority providing verification: (state, name, and title)		
Applicant was credentialed by: <input type="checkbox"/> Written Examination	Date:	Score:
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: _____



Washington State Department of

Health

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360-236-4700

Data Submission Attestation

Please note: the data submission attestation must be completed at the time of renewal only.

I hereby certify that I have submitted data on all courses of care for every mother and newborn as required in [WAC 246-834-370\(1\) and \(2\)](#).

Signature

Date

Current Plan For Consultation, Emergency Transfer, and Transport

Midwife name and License #

Date

1. The licensed physician or physician group who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:

Name

Phone number

Address

City

State

Zip Code

If more than one consultant, use page two of this form.

2. In an emergency transport to a hospital the following are available:

Private ambulance or municipal aid car

Phone Number

City

State

Zip Code

3. In the event of a maternal emergency in an out-of-hospital setting, I will transport to the following:

Hospital Name:

Location

4. In the event of a neonatal emergency in an out-of-hospital setting, I will transport to the following:

Hospital Name

Location

Midwife name and License #	Date
1a. Another licensed physician or physician group who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:	
Name	Phone Number
Address	
1b. Another licensed physician or physician group who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:	
Name	Phone Number
Address	
1c. Another licensed physician or physician group who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:	
Name	Location
Address	
1d. Another licensed physician or physician group who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:	
Name	Location
Address	
1e. Another licensed physician or physician group who is engaged in active clinical obstetrical practice and with whom I will consult when there are significant deviations from the normal in either the mother or the infant is:	
Name	Location
Address	



Washington State Department of
Health

Midwifery Credentialing
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360-236-4700

Washington Specific Review of Legend Drugs and Devices WAC 246-834-250 Preceptor Sign-off Form

In order to ensure that Certified Professional Midwife applicants have obtained sufficient education and training in the use of obstetric pharmacological agents they must obtain their preceptor's signature certifying that the applicant knows the correct usage and administration of the following pharmacological agents and supplies. See [RCW 18.50.115](#) and [WAC 246-834-250](#).

Applicant Name:	
Pharmacological Agents	Preceptor Signature
Rho immune globulin (human) (RhoGAM)	
IV fluids (limited to Lactated Ringers, 5% Dextrose with Lactated Ringers, Heparin, and .9 Sodium Chloride for use in IV locks.	
Sterile water for intradermal injections for pain relief.	
Local Anesthetic	
Antibiotics for intrapartum prophylaxis of Group Beta Hemolytic Streptococcus (GBS) per current CDC guidelines	
Postpartum Oxytocic	
Magnesium sulfate (for prevention of maternal seizures pending transport)	
Epinephrine (for use in maternal anaphylaxis pending transport)	
Terbutaline (for non reassuring fetal heart tones and/or cord prolapse pending transport)	
Anti hemorrhagic drugs to control postpartum hemorrhage, such as knows the correct usage and administration of the following pharmacological agents and supplies: <ul style="list-style-type: none"> • Misoprostel per rectum (for use only in postpartum hemorrhage); • Oral/intramuscular methylergonovine maleate (in the absence of hypertension); and • Intramuscular prostoglandin F2 alpha (hemobate). 	
Measles, mumps and rubella (MMR) vaccine to non-immune postpartum women	
Newborn prophylactic ophthalmic medication	
Vitamin K	
HBIG and HBV (for neonates born to hepatitis B positive mother)	

Supplies	Preceptor Signature
Dopplers	
Syringes, needles, phlebotomy equipment	
Sutures	
Urinary CAtheters	
Intravenous Equipment	
Amnihooks	
Airway suction devices	
Electronic fetal monitoring, toco monitoring	
Neonatal and adult resuscitation equipment	
Oxygen equipment	
Glucometer	
Centrifuge	

Applicant Signature: _____ Date _____

Preceptor Name: (please print) _____

Credential Type _____



Washington State Department of

Health

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

Disability Accommodation Request

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. [Section 504 of the Rehabilitation Act (29 USC 12101)]. Please call 360-236-4700 if you have questions about the types of accommodations available.

Name _____

Address _____

Phone _____ Social Security Number _____

Accommodations requested for the _____ Midwifery examination.

I have the disability _____ and request the following accommodation(s) at the testing site _____

Name (please print) _____

Signed _____ Date _____

Documentation of Disability Related Needs

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate licensed health care professional (doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, for example in your midwifery education program, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as a _____
Test applicant mm/yyyy Professional title

The applicant has the disability _____

diagnosed by the following tests or studies _____

I recommend the following accommodation(s) be provided for this individual _____

Name (please print) _____ Title _____

Address _____

Telephone _____ License Number _____

Signed _____ Date _____

If accommodations for testing were made for the candidate during progression through the Midwifery education program, provide a letter from the director indicating what modifications were made.

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Required Midwifery Courses

[RCW 18.50.040](#)
[WAC 246-834-140](#)

This form is for international applicants, out-of-state applicants, and applicants that did not graduate from a Washington State approved school. This form must be submitted directly from your midwifery program to the Department of Health.

Applicant Name _____

	Date	Course
1. Obstetrics, normal & abnormal	_____	_____
2. Neonatal Pediatrics/neonatology	_____	_____
3. Basic Sciences to include:		
Biology.....	_____	_____
Microbiology	_____	_____
Anatomy with emphasis on female reproductive anatomy	_____	_____
Physiology	_____	_____
Genetics	_____	_____
Embryology.....	_____	_____
Behavioral Sciences	_____	_____
4. Childbirth Education	_____	_____
5. Community Care.....	_____	_____
6. Obstetrical Care.....	_____	_____
7. Epidemiology	_____	_____
8. Gynecology, normal & abnormal	_____	_____
9. Family Planning	_____	_____

(Complete both pages of form)

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](#)

Online

[AIDS Training Resources, Reference Page](#)

[Midwifery Advisory Committee, Web Page](#)

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