Midwifery License 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
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 a education program that meets the Midwifery Education Accreditation Council (MEAC) standards.
           Graduate from an 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.

   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.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- 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. Inactive Practice:
Complete this section if you have not been in the active practice of midwifery prior to initial licensure for three or more years.

7. Other License, Certification, or Registration:
List all states where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

8. 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.

9. Applicant’s Attestation:
You must sign and date this for us to process the application.
License Requirements

If you graduated from a education program that meets the Midwifery Education Accreditation Council (MEAC) standards 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 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.
Midwifery License Application

Select one:  
☐ Graduate from an Education Program that meets that MEAC Standards  
☐ Graduate from an 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)

<table>
<thead>
<tr>
<th>Name</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

Birth date (mm/dd/yyyy)

Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

Country

<table>
<thead>
<tr>
<th>Phone (enter 10 digit #)</th>
<th>Fax (enter 10 digit #)</th>
<th>Cell (enter 10 digit #)</th>
</tr>
</thead>
</table>

Email address

Mailing address if different from above address of record

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

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

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.

   If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

   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.
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.

<table>
<thead>
<tr>
<th>Attendance</th>
<th>Name and address of institute, or place of practice</th>
<th>Degree Earned</th>
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<tbody>
<tr>
<td>Start mm/yyyy</td>
<td>End mm/yyyy</td>
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</table>

4. Experience

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

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<thead>
<tr>
<th>Attendance</th>
<th>Name and address of institute, place of practice</th>
<th>Type of experience or specialty</th>
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<td>Start mm/yyyy</td>
<td>End mm/yyyy</td>
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</table>
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. Inactive Practice -
Complete this section only if you have not been in active practice within the last three years. This section doesn’t apply to those who graduated in the last three years.

A preceptor is a licensed midwife or other obstetric practitioner license by their state or jurisdiction to provide maternity care who assumes responsibly for supervising the practical experience of a student midwife.

Preceptor Name | Preceptor License Number | State of Licensure
--- | --- | ---

If you have not been engaged in the active practice of midwifery for more than three years but less than five years, please complete this section.

I certify that I completed a minimum of 10 births while acting as a birthing assistant under the supervision of the above named preceptor within the last 12 months. I am enclosing documentation of proof of these 10 births.

I also certify that I have completed the continuing education requirements for the three years prior to submission of this application as shown in WAC 246-834-355.

Applicant’s Initials | Today’s Date
--- | ---

If you have not been engaged in the active practice of midwifery for more than five years, please complete this section.

I certify that I completed a minimum of 15 births while acting as a birthing assistant under the supervision of the above named preceptor within the last 12 months. I am enclosing documentation of proof of these 15 births.

I also certify that I have completed the continuing education requirements for the three years prior to submission of this application as shown in WAC 246-834-355.

Applicant’s Initials | Today’s Date
--- | ---

7. 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
--- | --- | --- | --- | --- | ---

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes
8. 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

9. Applicant’s Attestation

I, ________________________________, declare under penalty of perjury under the laws of the state 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/yyyyy)                        (city/state)

By: ______________________________
   (Original signature of applicant)
(This page intentionally left blank.)
## 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)].

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

## Current Plan For Consultation, Emergency Transfer, and Transport

<table>
<thead>
<tr>
<th>Midwife name and License #</th>
<th>Date</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

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

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

<table>
<thead>
<tr>
<th>Private ambulance or municipal aid car</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Hospital Name:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Location</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Hospital Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife name and License #</td>
</tr>
<tr>
<td>----------------------------</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>
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](https://apps.leg.wa.gov/rcw/default.aspx?cite=18.50.115) and [WAC 246-834-250](https://app.leg.wa.gov/wac/default.aspx?cite=246-834-250).

<table>
<thead>
<tr>
<th>Pharmacological Agents</th>
<th>Preceptor Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rho immune globulin (human) (RhoGAM)</td>
<td></td>
</tr>
<tr>
<td>IV fluids (limited to Lactated Ringers, 5% Dextrose with Lactated Ringers, Heparin, and .9 Sodium Chloride for use in IV locks.</td>
<td></td>
</tr>
<tr>
<td>Sterile water for intradermal injections for pain relief.</td>
<td></td>
</tr>
<tr>
<td>Local Anesthetic</td>
<td></td>
</tr>
<tr>
<td>Antibiotics for intrapartum prophylaxis of Group Beta Hemolytic Streptococcus (GBS) per current CDC guidelines</td>
<td></td>
</tr>
<tr>
<td>Postpartum Oxytocic</td>
<td></td>
</tr>
<tr>
<td>Magnesium sulfate (for prevention of maternal seizures pending transport)</td>
<td></td>
</tr>
<tr>
<td>Epinephrine (for use in maternal anaphylaxis pending transport)</td>
<td></td>
</tr>
<tr>
<td>Terbutaline (for non reassuring fetal heart tones and/or cord prolapse pending transport)</td>
<td></td>
</tr>
<tr>
<td>Anti hemorrhagic drugs to control postpartum hemorrhage, such as knows the correct usage and administration of the following pharmacological agents and supplies:</td>
<td></td>
</tr>
<tr>
<td>• Misoprostel per rectum (for use only in postpartum hemorrhage);</td>
<td></td>
</tr>
<tr>
<td>• Oral/intramuscular methylergonovine maleate (in the absence of hypertension); and</td>
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</tr>
<tr>
<td>• Intramuscular prostoglandin F2 alpha (hemobate).</td>
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<tr>
<td>Measles, mumps and rubella (MMR) vaccine to non-immune postpartum women</td>
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<tr>
<td>Newborn prophylactic ophthalmic medication</td>
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<tr>
<td>Vitamin K</td>
<td></td>
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<tr>
<td>HBIG and HBV (for neonates born to hepatitis B positive mother)</td>
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<tr>
<td>Supplies</td>
<td>Preceptor Signature</td>
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<tr>
<td>Dopplers</td>
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<tr>
<td>Syringes, needles, phlebotomy equipment</td>
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<tr>
<td>Sutures</td>
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<tr>
<td>Urinary Catheters</td>
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<tr>
<td>Intravenous Equipment</td>
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<td>Amnihooks</td>
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<tr>
<td>Airway suction devices</td>
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<tr>
<td>Electronic fetal monitoring, toco monitoring</td>
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<tr>
<td>Neonatal and adult resuscitation equipment</td>
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<tr>
<td>Oxygen equipment</td>
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<tr>
<td>Glucometer</td>
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<tr>
<td>Centrifuge</td>
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Applicant Signature: __________________________ Date ________________

Preceptor Name: (please print) __________________________

Credential Type ____________________________________________
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  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.

DOH 679-118 August 2017
## 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

<table>
<thead>
<tr>
<th>Date</th>
<th>Course</th>
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<tbody>
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</table>

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)
<table>
<thead>
<tr>
<th>Course</th>
<th>Date</th>
<th>Course</th>
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<tbody>
<tr>
<td>10. Medical/Legal Aspects of Midwifery</td>
<td></td>
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<tr>
<td>11. Nutrition during Pregnancy &amp; Lactation</td>
<td></td>
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<tr>
<td>12. Breast feeding</td>
<td></td>
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<td>13. Nursing skills to include:</td>
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<tr>
<td>Vital Signs</td>
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<td>Perineal Prep</td>
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<td>Catheterization</td>
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<td>Aseptic Techniques</td>
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<tr>
<td>Administration/Oral Medications</td>
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<tr>
<td>Administration/Injections</td>
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<td>Local Infiltration of Anesthesia</td>
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<td>Venipuncture</td>
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<td>Administration of Intravenous Fluids</td>
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<td>Infant &amp; Adult Resuscitation</td>
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<tr>
<td>Charting</td>
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<tr>
<td>14. Obstetrical Pharmacology</td>
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<tr>
<td>15. Student observed</td>
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<td>Number</td>
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<tr>
<td>16. Student managed</td>
<td></td>
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<td>Number</td>
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<tr>
<td>17. Student cared for</td>
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<tr>
<td>Number</td>
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<tr>
<td>18. Student cared for</td>
<td></td>
<td></td>
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<tr>
<td>Number</td>
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</tbody>
</table>

(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