THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Certified Direct-Entry Midwives
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *Midwives@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/Midwives*

Direct-Entry Midwife Certification by Examination Application Instructions

Average processing time for an application is four to eight weeks. Applications are reviewed in order of date of receipt in our office. If any of your application documentation requires additional information the review process may take longer. Apply far enough in advance to allow processing time.

In order to be scheduled for review by the board at its next regularly scheduled meeting, a complete application for certification and all supporting documents must be received by the division's office at least 30 days before the date of the next regularly scheduled meeting of the board. Board meetings are posted on the website: *ProfessionalLicense.Alaska.Gov/Midwives*

The following must be received by the division before your application for Direct-Entry Midwife Certification by Examination can be reviewed:

1. APPLICATION
A completed application, signed and notarized (#08-4215, pages 1-5).

2. FEES
Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	$ 500.00
Certification Fee:	$2,800.00
Total Fees Due:	$3,300.00

3. AUTHORIZATION FOR RELEASE OF RECORDS
A completed Authorization for Release of Records form (#08-4215a).

4. VERIFICATION OF CERTIFICATION
Verification of the following:
- Certification in Basic Life Support for Health Care Providers (BLS).
- Certified professional midwife certification in good standing from the North American Registry of Midwives (NARM).
- Certification in neonatal resuscitation from the Neonatal Resuscitation Program (NRP) from the American Academy of Pediatrics.

5. COURSE OF STUDY
To document completion of the required Course of Study in 12 AAC 14.200, one of the following must be submitted:
- An official transcript, diploma, or certificate of graduation from a midwifery program. This document must be an official copy mailed directly to the board from the institution where you completed your study.

– OR –

- An official transcript, diploma, or certificate of graduation or completion, sent directly to the department from a Midwifery Education Accreditation Council (MEAC)-accredited institution or from a midwifery school or program where the applicant completed the course of study.

6. DOCUMENTATION OF PHARMACEUTICAL KNOWLEDGE
Documentation of Pharmaceutical Knowledge (#08-4215e) as it pertains to Midwifery Practice.

7. VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE
A completed Verification of Supervised Clinical Experience form (#08-4215c).

8. CERTIFICATION OF COMPLETION OF PRACTICAL SKILLS LIST FOR CDMs
Certification of Completion of the Practical Skills List for Alaska CDMs (#08-4215h).

9. COMPETENCE IN PERMITTED PRACTICES
Documentation of Competence in Permitted Practices (#08-4215f).

General Information

CREDENTIAL INFORMATION:
The board will, in its discretion, issue a certificate without examination to an applicant who meets the requirements of AS 08.65.070 and 12 AAC 14.120. An applicant shall also provide documentation of fulfillment of the continuing competency requirements in 12 AAC 14.420 - 12 AAC 14.430 during the two years immediately preceding the date of application for certification. If you hold a current license in another jurisdiction and would like to apply for certification by credentials, you must use application #08-4198 entitled "Procedures for Obtaining Certification by Credentials as a Direct-Entry Midwife."

SPECIAL ACCOMMODATION(S) FOR EXAMINATION:
Programs under the jurisdiction of the Division of Corporation, Business and Professional Licensing are administered in accordance with the Americans with Disabilities Act (ADA). If you require special accommodation when taking the licensing examination, you must submit a completed "Application for Examination Accommodation for Candidates with Disabilities" form by the application deadline date. This form is available on the division's website: http://commerce.alaska.gov/cbpl/pl or contact the division to request the form**.**

APPLICATION PROCESSING:
The average time to process a paper application varies by program but can take several weeks from the date it is received in this office complete with all correct forms, supporting documents and appropriate fees paid. When the application is complete and correct, and all supporting documents have been received and all fees have been paid, the license will be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

LICENSE TERM:
There is no "inactive" status. If you choose not to renew your license, it will lapse. Licenses are issued for a two-year period and expire on March 31 of odd-numbered years, regardless of the date of issuance, except licenses issued within 90 days of the expiration date are issued to the next biennial expiration date. One renewal notice will be mailed at least 30 days before license expiration to the last known address of record.

PROFESSIONAL FITNESS QUESTIONS:
A "yes" response in the application does not mean your application will be denied. If you have responded "yes" to any professional fitness questions in the application, be sure to submit a signed and dated explanation, and the charging document and judgement.

DENIAL OF APPLICATION:
Please be aware that the denial of an application of licensure may be reported to any person, professional licensing board, federal, state, or local governmental agency, or other entity making a relevant inquiry or as may be required by law.

RANDOM AUDIT:
If your program requires continuing education, the Division will audit a percentage of the license renewals. If your license is randomly selected for audit, a letter will be sent with instructions to submit documentation as proof you satisfied the continuing competency requirements as stated on this renewal form. Licensees are randomly selected by computer and may be randomly selected as often as the computer program chooses. You must save your documents for at least four years so you can respond to audits.

ADDRESS OR NAME CHANGE:
In accordance with 12 AAC 02.900, it is the applicant's/licensee's responsibility to notify the Division, in writing, of changes of address or name. Name and address change notification forms are available on the Division's website. The address of record with the division will be used to send renewals and all other official notifications and correspondence. The name appearing on the license must be your current legal name.

CERTIFIED TRUE COPIES:
If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a "certified true copy of the original document". To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, "I certify this is a true copy of the original document" and sign your name. The notary will compare the original document with the copy and then notarize your signature.

SOCIAL SECURITY NUMBERS:
AS 08.01.060 and 08.01.100 require that a U.S. Social Security Number be on file with the division before a professional license is issued or renewed for an individual. If you do not have a U.S. Social Security Number, please complete the Request for Exemption from Social Security Number Requirement form (#08-4372) located at *ProfessionalLicense.Alaska.Gov* or contact the division for a copy of the form. This form is required with every application if you do not have a U.S. Social Security Number.

PUBLIC INFORMATION:
Please be aware that all information on the application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division's website at *ProfessionalLicense.Alaska.Gov* under License Search.

ABANDONED APPLICATIONS:
Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of biennial license and other fees paid. The application fee will not be refunded. If no request for refund is received within that timeframe, no refund will be issued, and all fees will be forfeited.

BUSINESS LICENSES:
The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. For more information about business licenses, (907) 465-2550 or *BusinessLicense.Alaska.Gov*

STALE DOCUMENTS:
Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

PAYMENT OF CHILD SUPPORT:
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

STATUTES AND REGULATIONS:
The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*

If you would like to receive notice of all proposed regulation changes for your program, please send a request in writing with your name, preferred contact method (mail or email), and the specific program you want to be updated on to the address below.

Regulations Specialist
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
EMAIL: *RegulationsAndPublicComment@Alaska.Gov*

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PART I Payment of Fees

Required Fees:	☐ Application and Certification Fee ($500 is Non-Refundable)	**$3,300.00**

PART II Personal Information

Full Legal Name:			

Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).

☐ Not Applicable
☐ Other Names Used: _____

Mailing Address:	P.O. Box or Street	City	State	Zip
Contact Phone:		**Date of Birth:**		

EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.

Email Address:		**Select One:**	☐ Send my Correspondence Electronically ☐ Send my Correspondence by Mail

Note: If both boxes are selected above, you will receive correspondence electronically.

SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.	

PART III Education

12 AAC 14.110(b)(4) requires verification of graduation from high school or its equivalent. Did you graduate from high school or complete an equivalent program?	☐ Yes ☐ No

PART IV Midwifery Training and Experience

State in chronological order all professional education and experience including college, university, technical or professional school, and practice pertaining to the profession for which you are making application.

Name Where Training Received:			
Location:		**Start Date:**	
End Date:		**Date Graduated or Completed:**	
Nature of Experience:	☐ College/University ☐ Technical/Professional School ☐ Apprenticeship		

Name Where Training Received:			
Location:		**Start Date:**	
End Date:		**Date Graduated or Completed:**	
Nature of Experience:	☐ College/University ☐ Technical/Professional School ☐ Apprenticeship		

Name Where Training Received:			
Location:		**Start Date:**	
End Date:		**Date Graduated or Completed:**	
Nature of Experience:	☐ College/University ☐ Technical/Professional School ☐ Apprenticeship		

Name Where Training Received:			
Location:		**Start Date:**	
End Date:		**Date Graduated or Completed:**	
Nature of Experience:	☐ College/University ☐ Technical/Professional School ☐ Apprenticeship		

Name Where Training Received:			
Location:		**Start Date:**	
End Date:		**Date Graduated or Completed:**	
Nature of Experience:	☐ College/University ☐ Technical/Professional School ☐ Apprenticeship		

PART V Professional License(s)

Please list all jurisdictions in which you hold or have held a professional license.

Jurisdiction	Profession	License Number	Issue Date	Expiration Date	Licensed By (Exam, Reciprocity, Other)

PART VI Medical Malpractice History

Have you ever had any claims of malpractice filed against you?	☐ No ☐ Yes

If "yes," please list all claims of malpractice filed against you below. Include all settlements, judgments, awards, and claims, even if no money was paid. For each case listed below, provide an explanation and documentation. Provide your explanation on a separate sheet of paper labeled with your name and signed by you; include a brief description regarding the nature of the case, the allegations, and your response to the allegations.

*Letters from attorneys or insurance carriers **may not** be substituted for this required explanation.* Documentation includes a copy of the order for settlement, dismissal, or removal from the case, or other documentation to support your explanation. Please do not send all of the motions or filings for the case.

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

Date of Case (mm/yyyy)	State or Jurisdiction	Nature of Allegation	Amount of Award or Settlement

PART VII Professional Fitness Questions

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "yes" response to any question, you must provide an explanation and documentation. Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

When in doubt, disclose and explain.

1. Have you been convicted of a crime or are you currently charged with committing a crime, or is any such action pending? For purposes of this question, "crime" includes a misdemeanor, felony, or a military offense, including (but not limited to) a conviction involving driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. "Convicted" includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine. ☐ **Yes** ☐ **No**

2. Have you had a professional license denied, revoked, suspended, or otherwise restricted, conditioned, or limited or have you surrendered a professional license, been fined, placed on probation, reprimanded, disciplined, or entered into a settlement with a licensing authority in connection with a professional license you have held in any jurisdiction including Alaska and including that of any military authorities or is any such action pending? ☐ **Yes** ☐ **No**

3. Are you currently the subject of any unresolved complaints or any unresolved disciplinary actions in another jurisdiction as far as you are aware? ☐ **Yes** ☐ **No**

4. Are you currently suffering from any condition, mental or physical, that impairs your judgment or that would otherwise adversely affect your ability to practice midwifery in a competent, ethical, and professional manner? ☐ **Yes** ☐ **No**

5. Do you use drugs or alcohol in any manner that impairs your ability to practice midwifery competently and safely? ☐ **Yes** ☐ **No**

"Yes" Answers

If you answered "yes" to questions 4 or 5, in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice as a midwife. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

PART VIII Attestations

☐ I certify I have reviewed AS 08.65.050(3) and AS 08.65.110 and attest that I have not engaged in conduct that is a ground for imposing disciplinary sanctions as referenced under AS 08.65.110.

- OR -

☐ I certify I have reviewed AS 08.65.050(3) and AS 08.65.110 and attest I DO NOT MEET AS 08.65.110. I have included an explanation and the applicable legal documentation.

- AND -

☐ I certify per 12 AAC 14.140 the information provided on this application and all forms accompanying it are true and correct.

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Notary Signature Page

PART IX Notarized Signature

I hereby certify that I am the person herein named and subscribing to this application and that I have read the complete application, and I know the full content thereof. I declare that all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Notary Stamp				
	Applicant Printed Name:			
	Applicant Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

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Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my employment, educational records, and records pertaining to litigation, judgments, suits and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators.

I authorize the division to discuss my records with persons or organizations that are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the division.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization is given expressly in connection with the application (initial, renewal, reactivation) for issuance of a certificate as a direct-entry midwife.

I hereby release you, your organization, the Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business, and Professional Licensing and its investigators, and all others directly and/or indirectly involved in this matter from any liability or damage which may result from furnishing the information requested.

This authorization expires one (1) year from the date of my signature below.

Name:	First Middle Last		
Full Address:	P.O. Box or Street City State Zip		
Phone:		**Date of Birth:**	
Email:			
Signature:		**Date Signed:**	

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Verification of Supervised Clinical Experience Form Instructions

PART I (**#08-4215c** to be completed by the applicant)

- **a.** Observations
- **b.** Assists
- **c.** Primary

All births are to be listed in chronological order and numbered. Complete all lines, including the person supervising, primary and assistant for every birth on all parts.

Part I a. – List 10 birth observations as required by 12 AAC 14.210(b)(2).
Part I b. – List 20 birth assists with labor and delivery as required by 12 AAC 14.210(b)(3).
Part I c. – List 20 primary births with responsibility for labor and delivery as required by 12 AAC 14.210(b)(4).

CONTINUOUS CARE CLIENTS. As part of the supervised clinical experiences required, an applicant must have provided continuous care to at least 15 clients. "Continuous Care" means, for the same client, the applicant:

1. performed at least six prenatal visits;
2. observed, assisted with, or had primary responsibility for labor and delivery of the newborn and placenta;
3. performed a newborn examination; and
4. performed a postpartum examination of the mother.

Subtotals and the date you met the requirement must be indicated at the bottom of each page. You must list any and all births that you were involved with.

You must document, on a separate sheet of paper, any complications and their outcomes for **ALL** births listed. Note the birth number and type from form 08-4215c.

PART II (to be completed by the applicant)

In "a," you must list your primary preceptor and all secondary preceptors who supervised you during your apprenticeship. You must also write in the total number of each activity under each preceptor. Make additional copies of the page as needed.

In "b," you must give the totals of your experiences for the complete apprenticeship. Enter ONLY one final total, regardless of how many preceptors you worked under.

PART III (to be completed by preceptor(s))

Each preceptor that supervised you must complete a Part III form. The numbers given on the Part III form must match the numbers given on Part II A for each preceptor.

NOTE: Apprentice is required to comply with 12 AAC 14.130(e) an apprentice direct-entry midwife shall submit written notice to the department within 30 days after any addition or change to the relationship with the apprenticeship program preceptor.

ALL SECTIONS ON ALL FORMS MUST BE FILLED IN. MISSING INFORMATION WILL CAUSE DELAYS IN THE PROCESSING OF YOUR APPLICATION.

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Verification of Supervised Clinical Experience
Part I a. - Observations

Location	Continuous Care	Date of Birth	Weight	Sex	**S – Supervising Licensee** (MD-CNM-CDM) **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	# Prenatal Visits Conducted by Applicant	Newborn Exam	# Postpartum Exams Conducted by Applicant
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	

Location	Continuous Care	Date of Birth	Weight	Sex	**S – Supervising Licensee** (MD-CNM-CDM) **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	**# Prenatal Visits Conducted by Applicant**	**Newborn Exam**	**# Postpartum Exams Conducted by Applicant**
Totals:								

All birth observations must be reported. Make additional copies as needed.

Apprentice Name: _____

Apprentice Permit No.: _____ **Date Required Observations Met: _____**

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Verification of Supervised Clinical Experience

Part I b. - Assists

Location	Continuous Care	Date of Birth	Weight	Sex	**S – Supervising Licensee** (MD-CNM-CDM) **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	# Prenatal Visits Conducted by Applicant	Newborn Exam	# Postpartum Exams Conducted by Applicant
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	

Location	Continuous Care	Date of Birth	Weight	Sex	**S – Supervising Licensee** (MD-CNM-CDM) **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	# Prenatal Visits Conducted by Applicant	Newborn Exam	# Postpartum Exams Conducted by Applicant
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ______ P: ______ A:		☐ Yes ☐ No	
Totals:								

All birth assists must be reported. Make additional copies as needed.

Apprentice Name: ______________________________

Apprentice Permit No.: ____________ **Date Required Assists Met:** ____________

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Verification of Supervised Clinical Experience
Part I c. – Primary Births

Location	Continuous Care	Date of Birth	Weight	Sex	**S – Supervising Licensee** (MD-CNM-CDM) **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	# Prenatal Visits Conducted by Applicant	Newborn Exam	# Postpartum Exams Conducted by Applicant
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ________ P: ________ A:		☐ Yes ☐ No	

Location	Continuous Care	Date of Birth	Weight	Sex	**S – Supervising Licensee** (MD-CNM-CDM) **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	# Prenatal Visits Conducted by Applicant	Newborn Exam	# Postpartum Exams Conducted by Applicant
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
☐ Home ☐ Birth Center ☐ Hospital Transfer	☐ Yes ☐ No				S: ____ P: ____ A:		☐ Yes ☐ No	
Totals:								

All primary births must be reported. Make additional copies as needed.

Apprentice Name: ____________________

Apprentice Permit No.: ____________ **Date Required Primary Births Met:** ____________

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Verification of Supervised Clinical Experience

Part II a. – Sub-Totals

Primary Preceptor Name:		**Professional License Number:**	

Please list the total number of each activity under the above preceptor.

Primary Labor & Deliveries	Prenatal Visits	Assisted Labor Managements	Newborn Exams	Observations	Postpartum Exams

Primary Preceptor Name:		**Professional License Number:**	

Please list the total number of each activity under the above preceptor.

Primary Labor & Deliveries	Prenatal Visits	Assisted Labor Managements	Newborn Exams	Observations	Postpartum Exams

Primary Preceptor Name:		**Professional License Number:**	

Please list the total number of each activity under the above preceptor.

Primary Labor & Deliveries	Prenatal Visits	Assisted Labor Managements	Newborn Exams	Observations	Postpartum Exams

Primary Preceptor Name:		**Professional License Number:**	

Please list the total number of each activity under the above preceptor.

Primary Labor & Deliveries	Prenatal Visits	Assisted Labor Managements	Newborn Exams	Observations	Postpartum Exams

Part II b. – Final Totals – All Activities Per 12 AACC 14.210(b)

List the totals of your experiences for the complete apprenticeship. Enter ONLY one final total, regardless of how many preceptors you worked under.

Primary Labor & Deliveries	Assisted Labor Managements	Observations	Continuous Care Clients	Prenatal Visits	Newborn Exams	Postpartum Exams

Signature

I certify that the above information is true and correct to the best of my knowledge. I also understand that if I falsify any information, I may forfeit the opportunity to be certified in the State of Alaska.

Applicant Printed Name:			
Applicant Signature:		**Date Signed:**	

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Verification of Supervised Clinical Experience

Part III – To be completed by preceptor(s)

Applicant Name:			
Preceptor Name:		**Professional License Number:**	
License Type:		**State of Licensure:**	
Original Issue Date:		**Expiration Date:**	

I, the above-named preceptor, certify that the aforementioned applicant obtained clinical experience under my supervision, which included the following number of experiences (as documented on Part I a, b, and c of form #08-4215c):

Number	Activity
	Number of prenatal visits: 100 required, 20 of which must be initial exams
	Number of labor and delivery observations: 10 required.
	Number of assisted labor and deliveries: 20 required.
	Number of labors and deliveries of the newborn and placenta in which the applicant was the primary responsible person: 20 required.
	Number of newborn examinations: 40 required.
	Number of postpartum examinations of the mother: 50 required.

Per 12 AAC 14.210(e), d, documentation of clinical experience on Part I must include:

1. Date of birth.
2. Location of birth.
3. Infant's gender.
4. Infant's weight.
5. Name of person who assisted at the birth (A = Assistant).
6. Name of person who delivered the newborn and placenta (P = Primary Midwife).
7. Number of prenatal and postpartum visits applicant participated in on each client.
8. A detailed explanation of any complication and its outcome. (Please attach separate sheet of paper.)
9. A detailed explanation of any situation that required emergency transport. (Please attach separate sheet of paper.)

Signature

I certify that all information provided on this form is true and correct and that the care provided was within the scope of AS 08.65 and 12 AAC Chapter 14.

Preceptor Printed Name:			
Preceptor Signature:		**Date Signed:**	

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Documentation of Pharmaceutical Knowledge

12 AAC 14.570 MEDICATIONS:
Complete the following regarding the below medications as it pertains to the practice of midwifery in Alaska.

1. Xylocaine Hydrochloride

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

2. Cetacaine

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

3. Vitamin K

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

4. Rh Immune Globulin

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

5. Eye Prophylaxis (Neonatal)

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

6. Oxytocin

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

7. Diphenoxylate Atropine / Loperamide

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

8. Methylergonovine

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

9. Misoprostol

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

10. Carboprost Tromethamine (Hemabate)

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

11. Tranexamic Acid

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

12. Loperamide or Diphenoxylate/Atropine

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

13. Epinephrine

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

14. Diphenhydramine

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

15. Lactated Ringers and Saline

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

16. Lactated Ringers and Saline with Dextrose (5%)

Indication:			
Dose (Range):		**Method of Administration:**	
Side Effects:			
Contraindications:			
Pharmacology / Actions:			

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12 AAC 14.560 - Permitted Practices

Document your competence in the following permitted practices by providing the resources of your training and skills. Each permitted practice must then be signed by your preceptor.

☐ Catheterization of the Urinary Bladder	
Resources:	
I certify that the applicant has acquired the training and skills necessary to safely perform catheterization of the urinary bladder.	
Preceptor Signature:	

☐ Administration of medications as specified in 12 AAC 14.570.	
Resources:	
I certify that the applicant has acquired the training and skills necessary for administration of medications as specified in 12 AAC 14.570.	
Preceptor Signature:	

☐ Emergency measures as specified in 12 AAC 14.600.	
Resources:	
I certify that the applicant has acquired the training and skills necessary to safely perform emergency measures as specified in 12 AAC 14.600.	
Preceptor Signature:	

☐ Venipuncture	
Resources:	
I certify that the applicant has acquired the training and skills necessary to safely perform venipuncture.	
Preceptor Signature:	

☐ Capillary Blood Sampling	
Resources:	
I certify that the applicant has acquired the training and skills necessary to safely perform capillary blood sampling.	
Preceptor Signature:	

☐ Suturing	
Resources:	
I certify that the applicant has acquired the training and skills necessary to safely perform suturing.	
Preceptor Signature:	

☐ Intravenous Therapy	
Resources:	
I certify that the applicant has acquired the training and skills necessary to safely perform intravenous therapy.	
Preceptor Signature:	

☐ Episiotomy	
Resources:	
I certify that the applicant has acquired the training and skills necessary to safely perform an episiotomy.	
Preceptor Signature:	

☐ Intravenous Treatment with Antibiotics for Group B Streptococci	
Resources:	
I certify that the applicant has acquired the training and skills necessary to safely perform intravenous treatment with antibiotics for Group B Streptococci.	
Preceptor Signature:	

VBAC Training

In accordance with 12 AAC 14.560(b) and (c), I certify that I have received at least six hours of training and education in prenatal care, vaginal delivery, and postpartum care for a client with a previous cesarean section.

- ☐ Yes, I intend to perform these practices and am submitting documentation of this training with this renewal form. I understand that I may not perform these practices on a post-cesarean client until I receive notification of acceptance of this documentation by the board.
- ☐ No, I do not intend to perform these practices.

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Certification of Completion of the Practical Skills List for Alaska CDMs

This form is to be completed by the applicants primary preceptor to verify that the applicant has completed the skills list required by 12 AAC 14.210(f).

Primary Preceptor Name:			
Apprentice Name:			
I certify that I have acted as the primary preceptor for the apprentice above. By my signature below, I verify that this apprentice has completed all of the practical skills listed on the PRACTICAL SKILLS LIST FOR ALASKA CERTIFIED DIRECT-ENTRY MIDWIVES. I further certify that for each skill completed under the supervision of a secondary preceptor, I have received the form "Preceptor Verification of Practical Skills List for Alaska CDM's" (page 46 of the skills list) signed and notarized by the secondary preceptor, verifying that the skill(s) has been completed. I am in possession of the completed skills list and agree to keep it as required by 12 AAC 14.210(f) and will make it available for the board's review upon request.			
Primary Preceptor Printed Name:			
Primary Preceptor Signature:		**Date Signed:**	

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Letter of Explanation for a Professional Fitness "Yes" Answer

Use this form only to explain and document any professional fitness "yes" answers. A "yes" answer is not necessarily disqualifying but concealing one may be.

Each "yes" answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check "yes" to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include, but not be limited to, suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple "yes" answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted according to state law.

☐ ⇦ **Write the professional fitness question number you are answering "yes" to in the box.**

Location of Incident:		**Date of Incident:**	
Explanation of Incident: When in doubt, disclose and explain. *Make copies as necessary.*			

Did you attach all applicable documents associated with this incident?

☐ Court Orders ☐ Consent Agreements ☐ Disciplinary Actions ☐ Charging Documents

☐ Court Records ☐ Fitness to Practice ☐ All Other Documentation Related to This Incident

☐ I have additional incidents for this "yes" answer, or "yes" answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

Full Name:		**Program:**	
Signature:		**Date Signed:**	

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Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Profession Type (e.g., Acupuncture):

License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(fine, exam, etc.)*: _____ _____

1. _____ _____
2. _____ _____

TOTAL: _____

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: X _____

08-4438 Rev 12/06/2022 Credit Card Payment Form (all major cards accepted)

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!

1. Credit Card Number: -
2. Expiration Date: -
3. Security Code: -

All 3 fields **MUST** be completed!

This section will be destroyed after the payment is processed.