State of Alaska
Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
BOARD OF CERTIFIED DIRECT-ENTRY MIDWIVES
State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550 ★ Fax: (907) 465-2974
E-mail: license@alaska.gov
Website: http://commerce.alaska.gov/cbpl/pl

PROCEDURES FOR OBTAINING CERTIFICATION BY EXAMINATION AS A DIRECT-ENTRY MIDWIFE

Applications to take the Northern American Registry of Midwives Examination (NARM) must be received in the division Juneau office at least 60 days before the date of the examination for which you are applying. See page 2 for additional 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 Juneau office at least 30 days before the date of the next regularly scheduled meeting of the board. Board meetings are posted on the website, *http://commerce.alaska.gov/dnn/cbpl/ProfessionalLicensing/Midwives.aspx*.

The following items must be submitted before your application will be reviewed per 12 AAC 14.110:

☐ 1. Complete, notarized application form, including photograph. (form 08-4215)

☐ 2. Nonrefundable application fee - $500.00.

☐ 3. Copy of current certification in:

- ☐ (A) Basic Life Support for Health Care Providers (BLS).
- ☐ (B) Neonatal Resuscitation;
- ☐ (C) intravenous therapy treatment for Group B *Streptococci,* from the Midwives' Association of Alaska (MAA), or from a program approved by the Midwifery Education Accreditation Council (MEAC); and
- ☐ (D) intravenous therapy from the Midwives' Association of Alaska (MAA), or from a program approved by the Midwifery Education Accreditation Council (MEAC).

☐ 4. Authorization for Release of Records (form 08-4215a).

☐ 5. Attests to 12 AS 08.65.050(3) for Professional Fitness.

☐ 6. Proof of passing the examination prepared and graded by the North American Registry of Midwives (NARM). These results must be mailed directly to the board from NARM.

☐ 7. Course of Study: To document completion of the required Course of Study, one of the following must be submitted:

- An official transcript, diploma, or certificate of graduation from a MEAC accredited institution. This document must be an official copy mailed directly to the board from the institution where you completed your study.
  -OR-
- Course of Study Certification form (form 08-4215d). This form must be signed by your Primary Preceptor and the Course of Study Provider, both must be notarized.

☐ 8. Pharmacology Protocols (form #08-4215e) Documentation of Pharmaceutical Knowledge as pertains to Midwifery Practice.

☐ 9. Verification of Supervised Clinical Experience, Parts I, II and III (form 08-4215c).

☐ 10. Verification of Licensure (form 08-4215g). The Verification of Licensure form must be completed by and mailed directly to the board from all states in which you hold or have held a permit or license to practice midwifery.

☐ 11. Certification of Completion of the Practical Skills List for Alaska CDM's. (Form 08-4215h)

☐ 12. Certification fee of $3800.00. The certification fee can be submitted after board approval; however, certification cannot be issued until the fee has been received. Payment by credit card may be made by using the Credit Card Authorization Form at: *http://commerce.alaska.gov/cbpl/pl.*

☐ 13. Documentation of Competence in Permitted Practices (form 08-4215f).

A wall certificate suitable for framing can be obtained by submitting a written request along with the $20.00 fee pursuant to 12 AAC 02.105(8).

EXAMINATION INFORMATION

Applications to take the Northern American Registry of Midwives Examination (NARM) must be received in the division Juneau office at least 60 days before the date of the examination for which you are applying. The NARM examination is offered in Anchorage. Contact the division for specific examination and application deadline dates. To be considered for examination, the following documents must be received by the deadline date:

1. Items 1-3(A & B), 4 and 5 listed on the front cover sheet.
2. Academic Program Completion form completed by preceptor (form 08-4215b).

The examination fee must be paid directly to NARM. Instructions for registering with NARM will be sent to applicants upon board approval of examination application.

Upon successful passage of the examination, all other requirements listed on the cover sheet must be submitted and approved by the board before certification will be issued. In order to be scheduled for review by the board at its next regularly scheduled meeting, the additional documentation required for certification/licensure, items 3 C and D, and Items 7 through 14 (and Item 6 if you have already passed the NARM examination) must be received by the division's Juneau office at least 30 days before the date of the next regularly scheduled meeting of the board. The board generally meets in February and August. Contact the division for specific dates and deadlines.

An applicant who has failed the examination may not retake the examination for a period of six months. In addition, an applicant who has failed the examination more than one time may not retake the examination unless the applicant has participated in or successfully completed further education and training programs as prescribed by the board.

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.

SOCIAL SECURITY NUMBER

In accordance with AS 08.01.060, the department is not authorized to issue a license unless the applicant's social security number has been provided to the department. If you do not have a social security number, you may download the Request for Exception from Social Security Number Requirement form at *http://commerce.alaska.gov/cbpl/pl* or contact the division.

PAYMENT OF CHILD SUPPORT AND STUDENT LOANS

If the Alaska Commission on Postsecondary Education has determined you are in loan default or if the Alaska Child Support Enforcement Division has determined you are in arrears on child support, you will be issued a nonrenewable temporary license valid for 150 days. Contact Postsecondary Education at 1-800-441-2962 or (907) 465-2962 or Child Support Services at (907) 269-6657 if your last name begins with A – M; Contact (907) 269-6845 if your last name begins with N – Z; or 1-800-478-3300 to resolve payment issues.

GENERAL INFORMATION

All certificates expire December 31 of even-numbered years regardless of when issued, except new certificates issued within 90 days of the expiration date will be issued through the next biennial license period.

MID

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For Division Use Only

APPLICATION FOR CERTIFICATION BY EXAMINATION AS A DIRECT-ENTRY MIDWIFE

I hereby apply for: Certification by Examination

Direct-Entry Midwife	Nonrefundable Application Fee:	$500.00
	Certification Fee:	$3800.00
	Wall Certificate (optional):	$20.00

Applicant's Name: _____
Last First Middle

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Daytime Telephone Number: _____ Social Security Number: _____

Email Address: _____ Gender: ☐ Female ☐ Male Date of Birth: _____

Have you taken the North American Registry for Midwives (NARM) examination? ☐ Yes ☐ No

Have you passed the NARM examination?
☐ Yes - provide date you passed the exam: _____

☐ No – provide date you would like to take the exam: _____

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

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.

From Mo/Day/Yr	To Mo/Day/Yr	Name and Location Where Training Received	Nature of Experience	Date Graduated or Completed

PREVIOUS REGISTRATION – List all jurisdictions in which you hold or have held professional licenses.

Jurisdiction	Profession	License No.	First Issue Date	Expiration Date	How Licensed (exam, reciprocal, other)

PROFESSIONAL FITNESS (Alaska Statute 08.65.050(3), AS 08.65.110 and 12 AAC 14.140)
If any of the following questions are answered "yes," full details must be furnished on a separate piece of paper and attached to this application.

		YES	NO
1.	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?	☐	☐
2.	Have you been convicted of a crime or are you currently charged with committing a crime? 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.	☐	☐
3.	Within the last five years, have you experienced or been treated for bipolar disorder, schizophrenia, paranoia, depression (except for situational or reactive depression), psychotic disorder, or other mental or physical disability?	☐	☐
4.	Within the last five years, have you been treated for substance abuse, or have you been addicted to, or excessively or illegally used alcohol or a controlled substance which may impair or interfere with your ability to practice midwifery?	☐	☐
5.	List below any malpractice actions that have been filed against you, including the nature of the case, date, and address of court where it is filed, and case status.		

_____

_____

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

AND

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

If you answered "Yes" to any questions or statements, please submit a signed and dated detailed statement of explanation and a copy of the legal documentation, if applicable. All information supplied with the application is considered public information, except information considered to be private by state or federal law. Licensee information, including mailing addresses, is available on the division's website at *www.commerce.alaska.gov/occ* under License Search.

_____
Signature of Applicant

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20_____.

ATTACH RECENT PHOTOGRAPH HERE

Passport size taken within one year of application

SEAL
Notary seal must cover portion of photograph.

_____
Notary Public

Notary Public for _____

My Commission Expires: _____

WARNING:
Alaska Statute 11.56.210 states that any person who knowingly, or intentionally, furnishes false or fraudulent information in an application has committed a class A misdemeanor. Any false or misleading information may result in failure to obtain registration or subsequent revocation of registration.

Department of Commerce, Community, and Economic Development
Division of Corporations, Business & Professional Licensing
Board of Certified Direct-Entry Midwives
P.O. Box 110806
Juneau, Alaska 99811-0806
(907) 465-2550
E-mail: license@alaska.gov

AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, _____, residing at _____

_____, authorize the Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine my medical, employment, education 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 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 which 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.

This release also applies to any documents or records which contain information pertaining to psychiatric, drug or alcohol evaluation, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis, or treatment.

I request that upon presentation of this release, or a Certified True Copy, 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 my application for a permit to practice as a direct-entry midwife.

Home
Telephone: _____

Work
Telephone: _____

Signature: _____ Date: _____

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
Board of Certified Direct-Entry Midwives
P.O. Box 110806
Juneau, Alaska 99811-0806
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E-mail: license@alaska.gov

ACADEMIC PROGRAM COMPLETION CERTIFICATION

(Required for examination application)
12 AAC 14.200(c)(2)

The following section needs to be completed by the applicant's course of study provider.

I, _____, certify that
(Name of Course of Study Provider)

_____ has completed the academic portion
(Student Name)

of her/his apprenticeship under my direction on this date _____. The academic
(Date of Completion)

program meets the course of study requirements of 12 AAC 14.200.

_____
Signature of Course of Study Provider

_____
Name of Course of Study

_____
Address

_____
City, State, Zip

SUBSCRIBED AND SWORN TO before me this _____ day of _____ 20_____.

_____
Notary Public

SEAL

My Commission Expires: _____

INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

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

- **a. Observes**
- **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 30 **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.

Department of Commerce, Community, and Economic Development
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PART I a. – OBSERVES - VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Location of Birth Observes Attended (City & State) *(Do Not Write in Patient Names)*	**Date of Birth, Weight and Sex in Chronological Order**	**S – Supervising Licensee (MD-CNM-CDM)** **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	**No. of Prenatal Visits Conducted by Applicant**	**Newborn Exam Yes/No**	**No. of Postpartum Examinations of Mother Conducted by Applicant**
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	

Totals This Page	**Observes**		**Prenatal Visits**	
	Continuous Care Clients		**Newborn Exams**	
			Postpartum Exams	

All *birth observes must be reported,*
make additional copies of this page as needed.

Date Required Observes Met: ______________________
Apprentice Name: ______________________
Apprentice Permit Number: ______________________

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PART I b. – ASSISTS - VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Location of Birth Assists Attended (City & State) *(Do Not Write in Patient Names)*	**Date of Birth, Weight and Sex in Chronological Order**	**S – Supervising Licensee (MD-CNM-CDM)** **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	**No. of Prenatal Visits Conducted by Applicant**	**Newborn Exam Yes/No**	**No. of Postpartum Examinations of Mother Conducted by Applicant**
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	

Totals This Page		
	Assists with Labor Management	
	Prenatal Visits	
	Newborn Exams	
	Postpartum Exams	
	Continuous Care Clients	

PART I b. – ASSISTS
CONTINUED ON NEXT PAGE

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PART I b. – ASSISTS - VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Location of Birth Assists Attended (City & State) *(Do Not Write in Patient Names)*	**Date of Birth, Weight and Sex in Chronological Order**	**S – Supervising Licensee (MD-CNM-CDM)** **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	**No. of Prenatal Visits Conducted by Applicant**	**Newborn Exam Yes/No**	**No. of Postpartum Examinations of Mother Conducted by Applicant**
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ______ Weight ______ Sex ______	S: ______ P: ______ A: ______		YES ☐ NO ☐	

Totals This Page		
	Assists with Labor Management	
	Prenatal Visits	
	Newborn Exams	
	Postpartum Exams	
	Continuous Care Clients	

Date Required Assists Met: ______________________

Apprentice Name: ______________________

Apprentice Permit Number: ______________________

All *birth assists must be reported, make additional copies of this page as needed.*

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PART I c. – PRIMARY - VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Location of Primary Births Attended (City & State) *(Do Not Write in Patient Names)*	Date of Birth, Weight and Sex in Chronological Order	S – Supervising Licensee (MD-CNM-CDM) P – Primarily Responsible for Labor & Delivery A – Assisted with Labor & Delivery	No. of Prenatal Visits Conducted by Applicant	Newborn Exam Yes/No	No. of Postpartum Examinations of Mother Conducted by Applicant
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	

Totals This Page			
	Primaries	**Prenatal Visits**	
	Continuous Care Clients	**Newborn Exams**	
		Postpartum Exams	

PART I c. – PRIMARY

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Department of Commerce, Community, and Economic Development
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PART I c. – PRIMARY - VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Location of Primary Births Attended (City & State) *(Do Not Write in Patient Names)*	Date of Birth, Weight and Sex in Chronological Order	S – Supervising Licensee (MD-CNM-CDM) P – Primarily Responsible for Labor & Delivery A – Assisted with Labor & Delivery	No. of Prenatal Visits Conducted by Applicant	Newborn Exam Yes/No	No. of Postpartum Examinations of Mother Conducted by Applicant
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number ____ Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	

Totals This Page				
	Primaries		**Prenatal Visits**	
	Continuous Care Clients		**Newborn Exams**	
			Postpartum Exams	

PART I c. – PRIMARY

CONTINUED ON NEXT PAGE

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
Board of Certified Direct-Entry Midwives
P.O. Box 110806, Juneau, Alaska 99811-0806
(907) 465-2550
E-mail: license@alaska.gov

PART I c. – PRIMARY - VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Location of Primary Births Attended (City & State) *(Do Not Write in Patient Names)*	**Date of Birth, Weight and Sex in Chronological Order**	**S – Supervising Licensee (MD-CNM-CDM)** **P – Primarily Responsible for Labor & Delivery** **A – Assisted with Labor & Delivery**	**No. of Prenatal Visits Conducted by Applicant**	**Newborn Exam Yes/No**	**No. of Postpartum Examinations of Mother Conducted by Applicant**
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	
Number Continuous Care Client Yes ☐ No ☐	DOB ____ Weight ____ Sex ____	S: ____ P: ____ A: ____		YES ☐ NO ☐	

Totals This Page				
	Primaries		**Prenatal Visits**	
	Continuous Care Clients		**Newborn Exams**	
			Postpartum Exams	

All primary births must be reported,
make additional copies of this page as needed.

Date Required Primary Births Met: ____________________

Apprentice Name: ____________________

Apprentice Permit Number: ____________________

PART II – VERIFICATION OF CLINICAL EXPERIENCE

A. **Sub-Totals** must be indicated for each supervising preceptor. You must list all preceptors, make additional copies of this page as needed.

TOTALS	Primary Preceptor Name:		Midwife License #:	
	Primary Labor & Deliveries		Prenatal Visits	
	Assisted Labor Managements		Newborn Exams	
	Observations		Postpartum Exams	

TOTALS	Primary Preceptor Name:		Midwife License #:	
	Primary Labor & Deliveries		Prenatal Visits	
	Assisted Labor Managements		Newborn Exams	
	Observations		Postpartum Exams	

TOTALS	Primary Preceptor Name:		Midwife License #:	
	Primary Labor & Deliveries		Prenatal Visits	
	Assisted Labor Managements		Newborn Exams	
	Observations		Postpartum Exams	

TOTALS	Primary Preceptor Name:		Midwife License #:	
	Primary Labor & Deliveries		Prenatal Visits	
	Assisted Labor Managements		Newborn Exams	
	Observations		Postpartum Exams	

B. Final Totals - All Activities

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

I declare 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's Signature ______________________________ Date: ______________________

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
Board of Certified Direct-Entry Midwives
P.O. Box 110806, Juneau, Alaska 99811-0806
(907) 465-2550
E-mail: license@alaska.gov

PART III – VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Applicants must verify clinical experience under the supervision of a preceptor who meets the qualifications of 12 AAC 14.210.

I, _____, certify that _____
(Name of Preceptor) *(Name of Applicant)*

obtained clinical experience under my supervision, which included the following number of experiences (as documented on **Part I a,b,c** of form 08-4215c):

_____ Number of prenatal visits (100 required for certification).
_____ Number of labor and delivery observations (10 required for certification).
_____ Number of assisted labor and deliveries (20 required for certification).
_____ Number of labors and deliveries of the newborn and placenta in which the applicant was the primary responsible person (30 required for certification).
_____ Number of newborn examinations (30 required for certification).
_____ Number of postpartum examinations of the mother (30 required for certification).

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 piece of paper.)
9. A detailed explanation of any situation that required emergency transport. (Please attach separate piece of paper.)

To be completed by person verifying experience.

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.

NOTARY SEAL

_____
Signature of Preceptor Date

_____
Type of License

_____ _____
CDM License No. State of Licensure

_____ _____
Original Issue Date Expiration Date

SUBSCRIBED AND SWORN TO before me, a notary public, in and for the state of _____

this _____ day of _____, 20____.

_____
Notary Public
My Commission Expires: _____

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
Board of Certified Direct-Entry Midwives
P.O. Box 110806, Juneau, Alaska 99811-0806
(907) 465-2550
E-mail: license@alaska.gov

COURSE OF STUDY CERTIFICATION

_____
(Name of Applicant)

Pursuant to 12 AAC 14.200(c), an applicant shall document completion of a course of study that meets the requirements of 12 AAC 14.200(a).

Pursuant to 12 AAC 14.200(d), the board may require documentation necessary to verify study of a subject, including an essay written by the applicant on subjects studied independently.

As the applicant, I certify that I have completed a course of study that meets the requirements of 12 AAC 14.200(a).

Printed Name of Applicant	Signature of Applicant	Date

As the course of study provider, I certify that the applicant has successfully completed the course of study required per 12 AAC 14.200(a).

Printed Name of Course of Study Provider	Signature of Course of Study Provider	Date

SUBSCRIBED AND SWORN TO before me, a notary public in and for the State of _____,

this _____ day of _____ 20____

NOTARY SEAL

_____
Notary Public

My Commission Expires: _____

As the preceptor, I certify that the applicant has successfully completed the required course of study and certification is true and correct to the best of my knowledge.

Printed Name of Primary Preceptor	Signature of Primary Preceptor	Date

SUBSCRIBED AND SWORN TO before me, a notary public in and for the State of _____,

this _____ day of _____ 20____

NOTARY SEAL

_____
Notary Public

My Commission Expires: _____

ONLY COURSE OF STUDY PROVIDER AND PRECEPTOR NEED TO NOTARIZE THEIR SIGNATURE

08-4215d (Rev. 01/26/17)

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:	

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

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

Receipt of your GBS/IV Therapy Certificate documents knowledge of and training of the following medications:

1. Lactated ringers, D5LR, NS
2. Antibiotic (CDC) guidelines
3. Epinephrine
4. Diphenhydramine

Applicant Name

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 off by your preceptor.**

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

Clamping & Cutting of the Umbilical Cord	Resources
I certify that applicant has acquired the training and skills necessary to safely perform clamping and cutting of the umbilical cord. Preceptor Signature: _____	

Artificial Rupture of the Amniotic Membranes	Resources
I certify that applicant has acquired the training and skills necessary to safely perform the artificial rupturing of amniotic membranes. Preceptor Signature: _____	

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

_____
Applicant Name

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 off by your preceptor.

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

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

Intramuscular Injection	Resources
I certify that applicant has acquired the training and skills necessary to safely perform intramuscular injections. Preceptor Signature: _____	

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

_____
Applicant Name

ALASKA STATE BOARD OF CERTIFIED DIRECT-ENTRY MIDWIVES
VERIFICATION OF LICENSURE

This form is essential to the application you are filing with this board. The information requested below must be officially verified by the licensing boards/agencies in all states of licensure. Please complete the information requested and forward it to the state(s) in which you hold or have held a license to practice. **You are advised to check with that state before forwarding this form to determine if there are additional requirements to be met before the information will be released, i.e., verification fee. (Copy this form as needed)**

PART I

TO BE COMPLETED BY THE APPLICANT (Please type or print legibly):

Last Name _____ First Name _____ Middle Name _____ Maiden Name _____

Mailing Address _____

City _____ State _____ ZIP Code _____

Date of Birth _____ License No. _____

I hereby request and authorize the State of _____ to provide any and all pertinent information requested in this form to the Board of Certified Direct-Entry Midwives in the State of Alaska to complete an application filed with that agency.

Signature _____ Date Signed _____

PART II – NOT TO BE COMPLETED BY THE APPLICANT

The above applicant is applying for licensure in Alaska. Please complete the following and **return directly to the Alaska State Board of Certified Direct-Entry Midwives, PO Box 110806, Juneau, AK 99801.**

State of _____

Name of Licensee _____

License No. _____ Original Issue Date _____

		YES	NO
☐ By reciprocity/endorsement/credentials	☐ By examination: State Board Examination	☐	☐
	NARM Examination	☐	☐

License is ☐ current _____ (Expiration Date) ☐ Lapsed _____ (Expiration Date)

If the applicant's license has lapsed or expired, please explain why (e.g., failure to pay licensing renewal fees, etc.)

_____

_____

CLINICAL EXPERIENCE REQUIREMENT

	YES	NO
Does your state require for licensure:	☐	☐
1. An apprenticeship?		
How long? _____	☐	☐
2. **Supervised** clinical experience including:		
a. at least 100 prenatal visits?	☐	☐
b. at least 10 labor and delivery observations (preceding any primary responsibility)?	☐	☐
c. at least 20 assisted labor managements (preceding any primary responsibility)?	☐	☐
d. primary responsibility for at least 30 labor and deliveries of newborn and placenta?.....	☐	☐
e. at least 30 newborn examinations?	☐	☐
f. at least 30 postpartum examinations of mother?.....	☐	☐

Has the applicant's license ever been suspended or revoked? ☐ No ☐ Yes

If yes, for what reason? _____

Has the applicant been subject to any other disciplinary action(s) (e.g., letter of warning, stipulation)? ☐ No ☐ Yes

If yes, please describe: _____

Please provide any information you believe relevant to the applicant's qualifications and fitness to practice midwifery:

Signed: _____

Printed Name: _____

Title: _____

SEAL

State Board: _____

Date: _____

Please return this form directly to:

Division of Corporations, Business and Professional Licensing
Alaska Board of Certified Direct-Entry Midwives
P.O. Box 110806
Juneau, AK 99811-0806

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
Board of Certified Direct-Entry Midwives
P.O. Box 110806, Juneau, Alaska 99811-0806
(907)465-2550
E-mail: license@alaska.gov

Certification of Completion of the Practical Skills List for Alaska CDM's

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)

I, _____, certify that I have acted as the primary
Primary Preceptor Name

preceptor for _____. By my signature below, I verify that this apprentice
Apprentice Name

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's Signature

Date: _____

SUBSCRIBED AND SWORN TO before me this _____day of _____, 20_____.

NOTARY SEAL

_____
Notary Signature

My Commission Expires: _____