



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) 465-2580 ** Fax (907) 465-2974
E-mail: license@alaska.gov
Website: www.commerce.state.ak.us/occ

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

The following items must be on file before your application will be considered by the board:

1. Complete, notarized application form, including photograph. (form 08-4215)
2. Nonrefundable application fee - \$100.00.
3. Certified true copy of current certification in Basic Life Support for Health Care Providers (BLS).
4. Certified true copy of current certification in:
 - (A) Neonatal Resuscitation;
 - (B) 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
 - (C) intravenous therapy from the Midwives' Association of Alaska (MAA), or from a program approved by the Midwifery Education Accreditation Council (MEAC).
5. Authorization for Release of Records (form 08-4215a).
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 submitted directly 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 notarized.
8. Pharmacology Protocols (Documentation of Pharmaceutical Knowledge as pertains to Midwifery Practice (form 08-4215e).
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 from all states in which you hold or have held licenses to practice midwifery.
11. Certification of Completion of the Practical Skills List for Alaska CDM's. (Form 08-4215h)
12. Certification fee of \$500.00. 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: www.commerce.state.ak.us/occ
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).

SEE REVERSE FOR INFORMATION CONCERNING EXAMINATION AND CREDENTIAL APPLICATION REQUIREMENTS.

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 generally offered on the third Wednesday in February and August of each year in Anchorage, Fairbanks and Juneau. 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 1-4(A) and 5 listed on the front cover sheet.
2. Academic Program Completion form completed by preceptor (form 08-4215b).

The examination fee of \$700.00 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 5 B and C, and Items 8 through 14 (and Item 7 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 on the last Thursday/Friday of 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 are licensed in another jurisdiction and would like to apply for certification by credentials, you must use a different application 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: www.commerce.state.ak.us/occ/ or contact the division to request the form.

SOCIAL SECURITY NUMBER

The department is not authorized to issue a license unless the applicant's Social Security Number is provided. If you do not have a United States Social Security Number, please complete the "Request for Exception from Social Security Number Requirement" form located on the divisions' website at www.commerce.state.ak.us/occ/ or contact the division for the form.

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.

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FOR OFFICE 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: \$100.00
Certification Fee: \$500.00
Wall Certificate (optional): \$20.00

Applicant's Name: Last First Middle

Mailing Address:

City: State: ZIP Code:

Daytime Telephone Number: Social Security Number:

Date of Birth: Gender: Female Male

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

Have you passed the NARM examination? Yes No

If "yes," provide date and location when passed:

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.

Table with 5 columns: 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.

Table with 6 columns: Jurisdiction, Profession, License No., First Issue Date, Expiration Date, How Licensed (exam, reciprocal, other)

PROFESSIONAL FITNESS (Alaska Statute 08.65.050(3) and AS 08.65.110)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever been disciplined by any state board or Midwife Association concerning violation of the Midwifery Practice Act or unethical conduct? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been the subject of an inquiry or under investigation by any state board or other licensing agency concerning a violation or alleged violation of any state regulation, statute or law, for any violation or alleged violation of unprofessional or unethical conduct pertaining to the profession for which you are applying? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been denied a certificate by, or the privilege of taking an examination before any state Midwife Board? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been convicted of any criminal offense other than a minor traffic violation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been convicted of a violation of any federal or state narcotic laws? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a license to practice midwifery revoked, suspended, restricted, or limited? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Within the past five years, have you been or are you addicted to, or excessively used or misused, alcohol, narcotics, barbiturates or habit-forming drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Within the past five years, have you been or are you being treated for bipolar disorder, schizophrenia, paranoia, psychotic disorder, substance abuse, depression (except for situational or reactive depression) or any other mental or emotional illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Within the past five years, have you had or do you have any disability or illness which could affect your ability to safely practice midwifery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. 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. | | |

If you answered "Yes" to any of these questions, please submit a detailed statement of explanation and 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.state.ak.us/occ under "Occupational License Search."

I certify that the information provided on this application is true and correct and all forms supplied by me are true and correct.

Signature of Applicant

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



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.

Notary seal must cover a portion of the photograph

SEAL

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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.

Signature: _____

Date: _____

My Date of Birth is: _____

Home Telephone: _____

Work Telephone: _____

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ACADEMIC PROGRAM COMPLETION CERTIFICATION
(Required for examination application)

The following section needs to be completed by the applicant's preceptor. (NOTE: If an applicant has more than one preceptor, please make photocopies and submit with the application.)

I, _____, am a
(Name of Preceptor - Print)

licensed _____ and have been practicing

for _____ year(s) and certify that _____ has

completed the academic portion of her/his apprenticeship under my direction. The academic program meets the course of study requirements of 12 AAC 14.200.

Signature of Preceptor

License/Certification Number _____

State _____

Date _____

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

SEAL

Notary Public

My Commission Expires: _____

PART I – VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Births Attended: Location		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 Management O – Observations	No. of Prenatal Visits Conducted by Applicant	Newborn Exam Yes/No	No. of Postpartum Examinations of Mother Conducted by Applicant
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
TOTALS	Primaries		TOTALS			
THIS PAGE	Assists with Labor Management		THIS PAGE	Prenatal Visits		
	Observations			Newborn Exams		
	Continuous Care Clients			Postpartum Exams		

**INSTRUCTIONS FOR COMPLETING THE FORM
“VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE”**

PART I (to be completed by the applicant)

Births are to be listed in **chronological order and each birth should be numbered**. The first ten births listed should be **observations**, as required by 12 AAC 14.210b, and at least the next 20 births listed should be assists with the labor management. Continuous care clients must be indicated.

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 must be indicated at the bottom of each page. You must list 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.

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.

In “B,” you must give the totals of your experiences for the complete apprenticeship.

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.

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

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Births Attended: Location		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 Management O – Observations	No. of Prenatal Visits Conducted by Applicant	Newborn Exam Yes/No	No. of Postpartum Examinations of Mother Conducted by Applicant
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
TOTALS	Primaries		TOTALS	Prenatal Visits		
THIS PAGE	Assists with Labor Management		THIS PAGE	Newborn Exams		
	Observations			Postpartum Exams		
	Continuous Care Clients					

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In “B,” you must give the totals of your experiences for the complete apprenticeship.

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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.

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		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			O: _____			
TOTALS	Primaries		TOTALS	Prenatal Visits		
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	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
TOTALS	Primaries		TOTALS	Prenatal Visits		
THIS	Assists with Labor Management		THIS	Newborn Exams		
PAGE	Observations		PAGE	Postpartum Exams		
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	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
TOTALS	Primaries		TOTALS			
THIS PAGE	Assists with Labor Management		THIS PAGE	Prenatal Visits		
	Observations			Newborn Exams		
	Continuous Care Clients			Postpartum Exams		

**INSTRUCTIONS FOR COMPLETING THE FORM
“VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE”**

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	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
TOTALS	Primaries		TOTALS	Prenatal Visits		
THIS PAGE	Assists with Labor Management		THIS PAGE	Newborn Exams		
	Observations			Postpartum Exams		
	Continuous Care Clients					

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	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
TOTALS	Primaries		TOTALS	Prenatal Visits		
THIS	Assists with Labor Management		THIS	Newborn Exams		
PAGE	Observations		PAGE	Postpartum Exams		
	Continuous Care Clients					

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			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
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			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
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			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____			
			O: _____			
TOTALS	Primaries		TOTALS	Prenatal Visits		
THIS	Assists with Labor Management		THIS	Newborn Exams		
PAGE	Observations		PAGE	Postpartum Exams		
	Continuous Care Clients					

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	Sex _____		A: _____			
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	Sex _____		A: _____			
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	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
	Number _____	DOB _____	S: _____		YES <input type="checkbox"/>	
		Weight _____	P: _____		NO <input type="checkbox"/>	
	Sex _____		A: _____			
Continuous Care Client <input type="checkbox"/> Yes <input type="checkbox"/> No			O: _____			
TOTALS THIS PAGE	Primaries		TOTALS	Prenatal Visits		
	Assists with Labor Management		THIS	Newborn Exams		
	Observations		PAGE	Postpartum Exams		
	Continuous Care Clients					

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			O: _____			
Number _____		DOB _____	S: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
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Number _____		DOB _____	S: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
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			O: _____			
Number _____		DOB _____	S: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
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			O: _____			
Number _____		DOB _____	S: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
		Weight _____	P: _____			
Continuous Care Client Yes <input type="checkbox"/> No <input type="checkbox"/>		Sex _____	A: _____			
			O: _____			
Number _____		DOB _____	S: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
		Weight _____	P: _____			
Continuous Care Client Yes <input type="checkbox"/> No <input type="checkbox"/>		Sex _____	A: _____			
			O: _____			
TOTALS THIS PAGE	Primaries		TOTALS	Prenatal Visits		
	Assists with Labor Management		THIS	Newborn Exams		
	Observations		PAGE	Postpartum Exams		
	Continuous Care Clients					

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	Number _____	DOB _____	S: _____	YES	YES	
		Weight _____	P: _____	<input type="checkbox"/>	<input type="checkbox"/>	
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			O: _____			
	Number _____	DOB _____	S: _____	YES	YES	
		Weight _____	P: _____	<input type="checkbox"/>	<input type="checkbox"/>	
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			O: _____			
	Number _____	DOB _____	S: _____	YES	YES	
		Weight _____	P: _____	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____	NO	<input type="checkbox"/>	
			O: _____			
	Number _____	DOB _____	S: _____	YES	YES	
		Weight _____	P: _____	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____	NO	<input type="checkbox"/>	
			O: _____			
	Number _____	DOB _____	S: _____	YES	YES	
		Weight _____	P: _____	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____	NO	<input type="checkbox"/>	
			O: _____			
	Number _____	DOB _____	S: _____	YES	YES	
		Weight _____	P: _____	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes No Continuous Care Client <input type="checkbox"/> <input type="checkbox"/>	Sex _____	A: _____	NO	<input type="checkbox"/>	
			O: _____			
TOTALS	Primaries		TOTALS	Prenatal Visits		
THIS	Assists with Labor Management		THIS	Newborn Exams		
PAGE	Observations		PAGE	Postpartum Exams		
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PART II – VERIFICATION OF CLINICAL EXPERIENCE

A. **Sub-Totals** must be indicated for each supervising preceptor.

T O T A L S	Primary Preceptor:		
	Primary Labor & Deliveries		Prenatal Visits
	Assisted Labor Managements		Newborn Exams
	Observations		Postpartum Exams

T O T A L S	Preceptor:		
	Primary Labor & Deliveries		Prenatal Visits
	Assisted Labor Managements		Newborn Exams
	Observations		Postpartum Exams

T O T A L S	Preceptor:		
	Primary Labor & Deliveries		Prenatal Visits
	Assisted Labor Managements		Newborn Exams
	Observations		Postpartum Exams

T O T A L S	Preceptor:		
	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: _____

PART III – VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

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

I, _____, certify that _____
Name of Supervisor Name of Applicant

obtained clinical experience under my supervision, which included the following number of experiences (as documented on Part 1 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 managements (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 Supervisor Date

Type of License

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: _____

COURSE OF STUDY CERTIFICATION

 (Name of Applicant)

Pursuant to 12 AAC 14.200(c), an applicant for certification as a direct-entry midwife must document a completed course of study by listing the resources used in the study of each requirement of 12 AAC 14.200(a).

An acceptable course of study for certification must include the following subjects. Please list the resource(s) used to fulfill each subject required. 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.

SUBJECT

RESOURCE(S)

HEALTH AND SOCIAL SCIENCES and SERVICES

(1) Communication, counseling, and teaching techniques including client education.	
(2) Human anatomy and physiology relevant to human reproduction.	
(3) Community standards of care, including standards for midwifery and medical standards for women during the childbearing cycle.	
(4) Communication and collaboration with community health and social resources for women and children.	
(5) Documentation of client care through the childbearing cycle.	
(6) Informed decision making.	
(7) Health education, health promotion, and self-care.	
(8) Clean and aseptic techniques and universal precautions.	

SUBJECT	RESOURCE(S)
(9) Psychosocial, emotional, and physical components of human sexuality, including indicators of common problems and methods of counseling.	
(10) Ethical considerations relevant to reproductive health.	
(11) Epidemiologic concepts and terms relevant to perinatal and women's health.	
(12) Principles of accessing and evaluating current research relevant to midwifery practice.	
(13) Family centered care including maternal, infant, and family bonding.	
(14) Appropriate referral of women and their families for treatment of disease.	
(15) Importance of accessible, quality health care for all women that includes continuity of care.	
ANTEPARTUM CARE	
(1) Preconceptional factors likely to influence pregnancy outcome.	
(2) Basic genetics, embryology, and fetal development.	
(3) Anatomy and assessment of the soft and bony structure of the pelvis.	
(4) Identification and assessment of the normal changes in pregnancy, fetal growth, and position.	

SUBJECT	RESOURCE(S)
(5) Nutritional requirements for pregnant women and methods of nutritional assessment and counseling.	
(6) Environmental and occupational hazards for pregnant women.	
(7) Education and counseling to promote health throughout the childbearing cycle.	
(8) Methods of diagnosing pregnancy including the testing of urine and blood.	
(9) Common discomforts of pregnancy, including the etiology and treatment of those discomforts, and the appropriate referral when indicated.	
(10) Assessment of physical and emotional status, including relevant historical and psychosocial data.	
(11) Counseling for individual birth experiences, parenthood, and changes in the family.	
(12) Screening and diagnostic tests used during pregnancy, including indications for use and the risks and benefits of the tests.	
(13) The etiology, assessment, treatment, and appropriate referral related to abnormalities of pregnancy.	
(14) Identification, implications, and the appropriate treatment of various sexually transmitted diseases (STD) and vaginal infections related to abnormalities of pregnancy.	
(15) Special needs of the women with Rh negative type blood.	
(16) Identification and care of women who are human immune deficiency virus (HIV) positive, have hepatitis, or have other diseases.	

INTRAPARTUM CARE	
(1) Normal labor and birth processes.	
(2) Anatomy of the fetal skull, including its critical landmarks.	
(3) Assessment of maternal and fetal status.	
(4) Emotional changes, comfort, and support during labor, birth, and immediately postpartum.	
(5) Techniques to aid the spontaneous vaginal delivery of the baby and placenta.	
(6) Abnormalities of the four stages of labor, including the etiology and assessment of those abnormalities and the appropriate referral, transport, and emergency measures indicated for the fetus, mother, or newborn affected by	
(6a) review of the side effects and administration of pharmaceutical agents, such as emergency administration of Pitocin to control postpartum hemorrhage; and	
(6b) performing an emergency episiotomy.	
(7) Adaption of the newborn to life after birth.	
(8) Medical interventions and technologies used during labor and birth.	
(9) Assessment and care of the perineum and surrounding tissues.	

POSTPARTUM CARE

(1) Anatomy and physiology of the newborn during the postpartum period.	
(2) Anatomy, physiology, lactation, and appropriate care of the breast.	
(3) Assessment and promotion of postpartum recovery.	
(4) The etiology and management of the discomforts of the postpartum period.	
(5) Emotional, psychosocial, and sexual changes that may occur during the postpartum period.	
(6) Nutritional requirements for women during the postpartum period.	
(7) Abnormalities of the postpartum period, including the etiology, assessment, treatment, and appropriate referral of the mother or newborn experiencing the abnormalities.	
(8) Assessment of the breast-feeding relationship, identification of lactation problems, and making appropriate referrals.	

NEONATAL CARE

(1) Anatomy and physiology of the newborn as they relate to the newborn's adaptation and stabilization in the first days of life.	
(2) Methods for assessing newborn status including relevant historical data and gestational age.	
(3) Nutritional needs of the newborn.	

(4) Administration of prophylactic treatments commonly used during the neonatal period, including state laws applicable to that administration.	
(5) Common screening tests for the newborns, including indications, risks, benefits, and methods of performing those tests.	
(6) Neonatal abnormalities, including the etiology and assessment of those abnormalities, and the screening and diagnostic tests, emergency measures, appropriate transport, referral, and treatment necessary as a result of those abnormalities.	

FAMILY PLANNING AND WELL WOMAN CARE

(1) Steroidal, mechanical, chemical, physiological, and surgical conception control methods.	
(2) Issues involved in decision making regarding unplanned pregnancies and resources for counseling and referral.	
(3) Abnormalities of the reproductive system and breast including the etiology and assessment of those abnormalities, and the treatment and appropriate referral of the woman experiencing those abnormalities.	
(4) Assessment of physical and emotional status, including relevant historical data.	

PROFESSIONAL, LEGAL, AND OTHER ASPECTS OF MIDWIFERY PRACTICE

(1) Peer review, chart review, case presentation, and developing midwifery protocols.	
(2) Data collection and analysis relevant to midwifery practice.	
(3) Laws governing the practice of midwifery in this state.	
(4) History of midwifery, medicine, and health care in the United States.	

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

XYLOCAINE HYDROCHLORIDE 1% OR 2%	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

CETACAINE	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

VITAMIN K	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

RHOGAM	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

EYE PROPHYLAXIS ILOTYCIN OR ERYTHROMYCIN	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

PITOCIN	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

METHERGINE	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

12 AAC 14.570 - Medications

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

LACTATED RINGERS, PLAIN OR WITH DEXTROSE 5%	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

12 AAC 14.570 - Medications

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

EPINEPHRINE	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

Document the training and skills you have acquired in order to safely and competently administer the following pharmaceutical agents in the practice of midwifery.

DIPHENHYDRAMINE	
Dosage	
Method of Administration	
Indications	
Contraindications	
Side Effects	
Pharmacology and Actions	

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: _____	

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: _____	

Has the applicant's license ever been suspended or revoked? _____ If so, for what reason? _____

Has the applicant been subject to any other disciplinary action(s) (e.g., letter of warning, stipulation)? _____ Please describe.

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

General Comments: _____

Signed: _____

Printed Name: _____

Title: _____

State Board: _____

Date: _____

SEAL

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 Occupational Licensing
Board of Certified Direct-entry Midwives
P.O. Box 110806, Juneau, Alaska 99811-0806
(907)465-2580
E-mail: license@commerce.state.ak.us

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: _____