



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINERS
COUNCIL OF CERTIFIED PROFESSIONAL MIDWIFERY
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384
www.tennessee.gov/health

APPLICATION INSTRUCTIONS FOR CERTIFICATION AS A MIDWIFE
APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee certificate to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Council.**

1. Complete, sign, have notarized, and mail the application pages 1 through 6.
2. Attach to the application a clear, recognizable, recently taken passport photograph of yourself.
3. If you are or have ever been licensed, certified, registered, or permitted by any state or country to practice as a Midwife or other health professional, you must complete and mail Attachment 1 to each and every state. Copies of Attachment 1 may be duplicated to accommodate each request.
4. Certification from NARM is a requirement. You must complete and mail Attachment 2 to the NARM office.
5. Submit two (2) original letters of recommendation from persons who can attest to your character as a Midwife. One (1) of the required letters shall be submitted from a health care professional. No letters from family members or relatives shall be accepted. These letters **must be originals** on the signator's letterhead.
6. Attach to the application a check or money order in the amount of \$1,010 made payable to the Council of Certified Professional Midwifery.
7. Submit proof of current CPR certification including infant or neonatal resuscitation. A notarized photocopy of current CPR certification attached to the application will be sufficient.
8. Effective June 1, 2006 applicants for initial licensure in Tennessee must obtain a criminal background check. For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>.
9. Complete Declaration of Citizenship.

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Council's administrative office, in writing, immediately.

1. All application fees are non-refundable.
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Council of Certified Professional Midwifery
665 Mainstream Drive
Nashville, TN 37243

For Federal Express or Special Courier:
Council of Certified Professional Midwifery
665 Mainstream Drive
Nashville, TN 37228

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Council asks that you please give the administrative office every consideration in this matter.
4. If necessary documentation has not been received when your application has been received by the Council's administrative office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Council's administrative office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.
5. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination and if your application is approved you will be able to view certification approval on the Internet.
6. It is recommended that you do not make arrangements to accept employment as a Certified Professional Midwife in Tennessee until you are granted certification by the Council of Certified Professional Midwifery.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have a Tennessee certificate issued by the Council of Certified Professional Midwifery in your possession before you may lawfully practice.



FOR OFFICIAL USE
ONLY

ATTACH A
CURRENT FULL-
FACE
PHOTOGRAPH

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

3045-001 \$1000
3045-006 \$ 10
\$1010

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APPLICATION FOR
CERTIFIED PROFESSIONAL MIDWIFE IN TENNESSEE

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden

Social Security Number: _____ - - Date of Birth: _____

Mailing Address _____

Zip _____

Practice Address _____

Zip _____

Phone: Home: () _____ Office: () _____

Place of Birth: _____ Sex: (optional, for statistical purposes only)

Female _____

Male _____

U.S. Citizen: Yes ___ No ___

Email address" _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space.

From:	_____	To:	_____	_____	_____
	Mo/Yr		Mo/Yr	Educational Institution	Location
From:	_____	To:	_____	_____	_____
	Mo/Yr		Mo/Yr	Educational Institution	Location
From:	_____	To:	_____	_____	_____
	Mo/Yr		Mo/Yr	Educational Institution	Location
From:	_____	To:	_____	_____	_____
	Mo/Yr		Mo/Yr	Educational Institution	Location

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

<u>DATES</u>		<u>LOCATION</u>		<u>POSITION AND DUTIES</u>
From:	_____	To:	_____	_____
	Mo/Yr		Mo/Yr	(City) (State)
From:	_____	To:	_____	_____
	Mo/Yr		Mo/Yr	(City) (State)
From:	_____	To:	_____	_____
	Mo/Yr		Mo/Yr	(City) (State)
From:	_____	To:	_____	_____
	Mo/Yr		Mo/Yr	(City) (State)
From:	_____	To:	_____	_____
	Mo/Yr		Mo/Yr	(City) (State)
From:	_____	To:	_____	_____
	Mo/Yr		Mo/Yr	(City) (State)
From:	_____	To:	_____	_____
	Mo/Yr		Mo/Yr	(City) (State)

LICENSURE INFORMATION

List below all states, countries, or provinces in which you have ever been or currently are licensed, permitted, or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than midwifery. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. *In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.*

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to exercise reasoned professional judgments, to learn, and keep abreast of developments in your profession;
 - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS

YES NO

- | | | |
|--|-------|-------|
| 1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? | _____ | _____ |
| a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? | _____ | _____ |
| b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? | _____ | _____ |

[If you receive such ongoing treatment or participate in such a monitoring program, the Council will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued whether conditions should be imposed or whether you are not eligible for licensure.]

COMPETENCY INFORMATION continued

		YES	NO
2.	Do you currently use chemical substances?	_____	_____
	If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	_____
	Please list: _____ _____		
3.	Are you currently engaged in the illegal use of controlled substances?	_____	_____
	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5.	If you have ever held or applied for a license or certificate to practice as a Midwife in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8.	Have you ever been rejected or censured by a professional society?	_____	_____
9.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you;	_____	_____
	b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
	c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
10.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____



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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you **hold or have ever held** a license to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a license or certificate to practice _____ (Profession)
numbered _____ on _____ in the State of _____ (Date).

The Council of Certified Professional Midwifery of Tennessee requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Council of Certified Professional Midwifery.

Date _____ Applicant's Signature _____
Applicant's typed or printed name _____

To Be Completed By Administrative Office of State Licensure Board

Name In Full As it Appears On License/Certificate or Permit:

(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Expiration Date: _____

Basis of Issuance: _____ Endorsement/Reciprocity with _____ (State)
(Check One) _____ Written Examination _____

Is the license currently active and registered? Yes _____ No _____
Is there any derogatory information on file? Yes _____ No _____ If yes, please attach supporting documentation.

Authorized Signature Title Date

Please mail directly to: Council of Certified Professional Midwifery
665 Mainstream Drive
Nashville, TN 37243



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NARM VERIFICATION

Please complete this form and mail it to the address below:

Send to:

North American Registry of Midwives
P.O. Box 7703
Little Rock, AR 72217-7703

To Be Completed By Applicant (Please Print In Ink)

Dear NARM Official:

I am applying for a certificate to practice as a Certified Professional Midwife in the State of Tennessee. The State Board of Osteopathic Examiners' Council of Certified Professional Midwifery requires that a credential letter be **forwarded directly to their** office by the NARM.

Applicant's Name: _____
(First) (Middle) (Last)

Applicant's Address: _____
(Street, City, State, Zip)

Social Security No.: _____ - _____ - _____ Credential # _____

Signature

PLEASE MAIL CREDENTIAL VERIFICATION DIRECTLY TO:

Council of Certified Professional Midwifery
665 Mainstream Drive
Nashville, TN 37243



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DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every *adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____.
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: _____
Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
4. I am a United States Citizen: ___Yes ___No
5. I am a foreign national not physically present in the United States ___Yes ___No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents

- b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this ____ day of _____, 20__.

Signature

Sworn to before me this ____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.