FOR OFFICE USE ONLY
Signature of Board Members

FOR OFFICE USE ONLY
Receipt #
ID #
Issue Date
License #

Rhode Island
Advisory Council on Midwifery

Room 105
3 Capitol Hill
Providence, RI 02908-5097

Instructions and License Application for

License As A

Midwife

Applicant - Print Name (First/MI/Last)

Phone: (401) 222-5700 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-3352**

Revised 08/27/2007 jcp

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Application Process Overview.....3

Instructions for Completing Application.....4

Application Materials

Application.....5-8
Application Checklist.....9
Interstate Verification Form - Original State of Licensure.....10
Interstate Verification Form - Other State(s) of Licensure.....11
RI Uniformed Controlled Substances Act Registration (CSR).....12
Mandatory Addendum to License Application (Verification of Social Security Number).....13

Licensure Requirements

- Application fee **$130.00**
- Recent passport type photograph
- Official transcript directly from educational program which includes the degree granted and date awarded
- Letter of certification directly from the American College of Nurse Midwives
- Chronological resume of experience from graduation from school of nursing to present
- Verification of licensure directly from the Board of Nursing/Midwifery in each state applicant has been granted a license to practice as an advanced practice nurse
- Three (3) original letters of recommendation signed by reputable persons. At least one letter should be from a present or past employer. If the applicant graduated from a midwifery school within the last five years, a second letter should be from the Director of the program.
- Completion of "Verification of Social Security Number" Form (page 13)

NOTE: *All applicants for prescriptive privileges who wish to prescribe controlled substances must complete the enclosed Rhode Island Uniform Controlled Substances Act Registration (CSR) (page 12). A Federal DEA registration number will not be issued without proof the practitioner has a Rhode Island issued CSR.* ***The fee for a CSR is an additional $140.00 (for a total of $270.00 if submitted at the same time as the midwife application)*** *for two years and will be renewable every other year with your midwifery license. The CSR can only be issued to a Rhode Island practice address.*

Applicants for licensure by endorsement may be eligible for a 90 day work permit if the following criteria are met:

1. The applicant holds a current out-of-state midwife license.
2. The applicant submits a completed application form and the appropriate fee, and
3. The applicant submits a photocopy of a current active out-of-state midwife license.

APPLICATION PROCESS OVERVIEW

90 Day Temporary License

Non- Renewable under any circumstances, and are issued **once**.

Rules and Regulations/Laws

The rules and regulations governing the Practice of Midwifery may be obtained at the following web site:

http://www.health.ri.gov/hsr/professions/midwife.php

Rhode Island General Laws pertaining to the Practice of Midwifery may be downloaded at the following web site:

http://www.rilin.state.ri.us/statutes/title23/23-13/23-13-9.HTM

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation, and the Rhode Island Advisory Council on Midwifery (Board).

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 9) must be received by this Office for an application to be considered complete. If you do not complete the application process and obtain a license within one year, a new application must be submitted.

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice, criminal or disciplinary history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received and a decision to be made regarding issuance of your license.

Licenses will be issued within 7-10 working days following the approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished on the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. Address changes may be emailed to the Board. The email address can be found at the following web site:

http://www.health.ri.gov/hsr/professions/midwife.htm

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed by the Board. Be advised, you may be required to appear for an interview. NOTE: You may ***not*** practice in Rhode Island until you have received a license number.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-5700.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application pages (5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages MUST clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee payable to **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NONREFUNDABLE.
3. Complete all application materials as instructed and arrange them in the order listed on the application checklist (page 9). Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

Rhode Island Department of Health
Advisory Council on Midwifery
Room 105, 3 Capitol Hill
Providence, RI 02908-5097

In addition to the materials you mail to HEALTH, the following must be either mailed or requested from other sources.

1. Official transcript from the school of midwifery must be submitted by the college/school/university, directly to the Board, at the address listed above. ***Fascimiles will not be accepted.*** This transcript includes the date of completion, graduation, and degree.
2. Interstate Verification Forms. The original state of licensure must be sent the form on Page 10, and all other licensing authorities in which you are/were licensed must be sent the form on Page 11 (which may be copied as needed). Be sure to sign and complete the identifying information on each form. HEALTH must receive these verifications directly from the licensing authority.

State of Rhode Island
Advisory Council on Midwifery

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., Dr., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

_____

_____

2. Social Security Number

U.S. Social Security Number

- For Internal Purposes Only -

3. Gender

☐ Male ☐ Female

4. Date and Place of Birth

Month Day Year 1 9

City and State; **OR** Province and Country, etc., if NOT U.S.

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended which led to your advanced practice license.

Type of School (University, College, Trade/Technical School etc.)

Name of School

Date Graduated: Month Day Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

Major

Specialty/Type

9. Certification

Please provide your Midwife Certification Information here.

Organization Granting Certification _____

Midwifery Certification Number _____

10. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, list the original state of licensure, license number, and, if applicable, enter all other state abbreviation(s) of licenses in Question 11 (below):

Original Licensure

State License Number

11. Midwifery Licensure

List all states or countries in which you are now, or ever have been licensed to practice as a midwife,or any other profession.

State/Country:			State/Country:		
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive

DOCUMENTATION: Send Interstate Verification Forms to each entity. *(See pages 10 and 11)*

12. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year
_____		
_____		
_____		

13. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

1. Are there any charges or investigations pending, in any state, against you? ☐ Yes ☐ No
2. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? ☐ Yes ☐ No
3. Have you ever had any disciplinary action(s) taken, or is any pending against your license to practice nursing, or any other licenses, registrations or certifications that you hold; or are any complaints pending in any state? ☐ Yes ☐ No

Note: If you answered "yes" to any of these questions you must explain below or, if needed, on a separate sheet of paper.

14. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Advisory Council on Midwifery any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as nurse in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Advisory Council on Midwifery of any change in the answers to these questions after this application and this affidavit is signed.

_____ Signature of Applicant

_____ Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ Name of Notary (Print, Type or Stamp)

_____ Signature of Notary

Notary Seal

_____ Notary No/Commission No.

_____ Commission Expiration Date (MM/DD/YY)

15. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

Affix Photo Here

Write your name on the back of the photograph, and provide the date that the photograph was taken.

_____ Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the Rhode Island Board application as instructed (pages 5-8).
- ☐ I have attached the cover page of the application.
- ☐ I have completed Section 14, **"Affidavit of Applicant"** (page 8), and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 15, **"Recent Photograph"** (page 8) as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have attached a photocopy of an active, out-of-state advanced practice license.
- ☐ I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the ***"RI General Treasurer"*** in the amount of **$130.00** (**or $270.00 with CSR**) and attached it to the upper left-hand corner of the first (Top) page of the application.
- ☐ I have arranged my Board Application materials in the following order.

  1. Fee (attached as instructed).
  2. Board Application (including cover page) (pages 5-8)
  3. "Mandatory Addendum to License Application - Verification of Social Security Number" Form (page 13)
  4. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application] MUST indicate the section for which the information is being reported.] Including

- ☐ I have mailed the above application materials directly to the Rhode Island Board of Nurse Registration and Nursing Education.

Required Forms

- ☐ I have completed and mailed the following forms as instructed.

  1. Interstate Verification Form - Original State of Licensure
  2. Interstate Verification Form - to all other states of licensure

Other Documents

- ☐ I have requested a school transcript as instructed.
- ☐ I have applied for the RI Uniformed Controlled Substances Act Registration (CSR), completed the form (page 12) and enclosed an **additional $140.00 (for a total of $270.00).**

Substitute forms are not acceptable - This form may be duplicated as needed.

Rhode Island Advisory Council on Midwifery
Room 105, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-5700

INTERSTATE VERIFICATION FORM - ORIGINAL STATE OF LICENSURE

I am applying for a license to practice as a midwife in the State of Rhode Island. The Rhode Island Advisory Council on Midwifery requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Advisory Council on Midwifery at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE MIDWIFERY BOARD

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Questions:

1. Has this midwife ever been investigated by your Board? ☐ Yes ☐ No
2. Has this midwife incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Substitute forms are not acceptable - This form may be duplicated as needed.

Rhode Island Advisory Council on Midwifery
Room 105, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-5700

INTERSTATE VERIFICATION FORM - OTHER STATES OF LICENSURE

I am applying for a license to practice as a midwife in the State of Rhode Island. The Rhode Island Advisory Council on Midwifery requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Advisory Council on Midwifery at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE MIDWIFERY BOARD

License Status:	Original Date Issued:	Expiration Date:
☐ Active ☐ Inactive ☐ Lapsed		

Questions:

1. Has this midwife ever been investigated by your Board? ☐ Yes ☐ No
2. Has this midwife incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Substitute forms are not acceptable - This form may be duplicated as needed.

Rhode Island Advisory Council on Midwifery

Room 105, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-5700

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniformed Controlled Substances Act Registration (CSR). **I understand that there is an additional $140.00 fee for this Registration and that the check or money order must be made out to the RI General Treasurer.**

Print/Type Full Name _____ Business Name _____ Current RI Midwife LicenseNo. _____

Signature _____ Business Address _____ Business Telephone _____

Date _____ Business Fax _____

Complete this application for registration to prescribe controlled substances in the State of Rhode Island

The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site:
www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm

Drug Schedule (Check all that apply)

☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ ScheduleV

A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.

The CSR is renewed at the same time that the professional license is renewed.

NOTE:
Read Important Information on the bottom of this application.

A Copy of the DEA Registration must be provided to the Midwifery Council within 60 Days of it's issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*

All Applicants MUST answer the following:

A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☐ No

B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? ☐ Yes ☐ No

If you answered "Yes" to question "A" or "B" attach an explanation to this form.

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "**VOID**". Licensed drug facilities and licensed practitioners with prescriptive privileges, cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: www.deadiversion.usdoj.gov./drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units maybe dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

Applicant: Print your complete last name >

Rhode Island Department of Health

3 Capitol Hill, Providence RI, 02908-5097

MANDATORY ADDENDUM TO LICENSE APPLICATION

Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case #_____)

☐ I am in state receivership. (Case #_____)

☐ I have been discharged from bankruptcy. (Case #_____)

_____

Type of Professional/Business License for which you are applying.

Full Name (Please Print or Type)	Social Security Number (or FEIN for Business)
Signature	Phone Number (including area code if not 401)
Date	Name of Business (If Applicable)

This form must be completed, signed and attached to your license application for processing.