

MIDWIFERY JOINT COMMITTEE STATE OF NORTH CAROLINA

APPLICATION FOR APPROVAL AS A CERTIFIED NURSE-MIDWIFE

GENERAL INFORMATION

1. **BEFORE COMPLETING APPLICATION**, photocopy blank forms for future use.
2. Initial applications for first-time approval in North Carolina are reviewed and approved by the Midwifery Joint Committee.
3. In general all other applications are approved administratively by the staff of the Midwifery Joint Committee.
4. Nurse-midwife applicant status may be granted if the graduate nurse-midwife, who is awaiting certification, has met the specified criteria as stated in the Administrative Rule (21 NCAC 33.0106).
5. Only those physicians actively engaged in the practice of obstetrics/gynecology are eligible to supervise the nurse-midwife. Therefore, only those physicians may sign the forms submitted to the Midwifery Joint Committee.
6. You are authorized to prescribe drugs and devices according to the Nurse Practitioner Rules as defined in 21 NCAC 36.0227(h). NOTE: See next page for prescription format.
7. If you are going to prescribe or order controlled substances, contact: Drug Enforcement Administration, Registration Unit, P. O. Box 28083, Central Station, Washington, DC 20005 (800) 882-9539; Atlanta office (888)219-8689, ext. 241 or the Greensboro Resident Office, 1801 Stanley Road, Suite 201, Greensboro, NC 27407 (336) 547-4219 for a copy of the Mid-Level Practitioner Manual and FORM DEA-224.

MATERIALS TO BE KEPT ON FILE AT EACH PRACTICE SITE:

1. Instructions on submitting application.
2. General Statutes (G. S. 90-178) and Administrative Rules (21 NCAC 33.0101-.0106).
3. Photocopy of initial application submitted to the Committee.
4. Written guidelines/protocols for clinical practice that include:
 - (a) Definition for the individual and shared responsibilities of the midwife and the supervising physician(s).
 - (b) Guidelines for ongoing communication, which provide for and define, appropriate consultation.
 - (c) A process for periodic and joint evaluation of services rendered, e.g. chart review, case review, patient evaluation, and review of outcome statistics by CNM and the primary supervising physician(s).
 - (d) A process for periodic and joint review and updating of the written clinical practice guidelines by the CNM and the supervising physician(s).
5. Statement of Approval from Midwifery Joint Committee
6. Photocopy of annual renewal application and approval
7. Other pertinent correspondence with the Midwifery Joint Committee

INTAPP.DOC

Adopted: 8/10/84

Revised: 6/85; 12/85; 11/93; 11/96' 1/00; 6/00; 7/00

PRESCRIPTION FORMAT

The prescribing number assigned by the Midwifery Joint Committee to the certified nurse-midwife (CNM) must appear on all prescriptions issued by the CNM.

PRESCRIPTION FORMAT

- All prescriptions issued by the CNM shall contain the primary supervising physician name, the name of the patient, and the CNM's name, telephone number, and prescribing number.
- The CNM's assigned DEA number shall be written on the prescription form when a controlled substance is prescribed.

Each prescription must be noted on the patient's chart and include the following information:

- (A) medication and dosage;
- (B) amount prescribed;
- (C) directions for use;
- (D) number of refills; and
- (E) signature of CNM

The following is an example of a format that meets current legal requirements in North Carolina.

John Q. Public, M.D.	ANYTOWN MEDICAL CENTER 1800 MEDICAL ARTS BLDG ANYTOWN, N.C. 28000	Shirley S. Nurse, CNM Phone # _____ CNM # _____
Name _____		
Address _____ Date _____		
RX		
Refill O 1 2 3 4		
_____		_____
(Product Selection Permitted)		(Dispense as Written)

To discourage forged prescriptions, the Boards suggest that the MJC ID numbers be only partially printed and be completed at the time the prescription is written, and that the DEA number shall be written on the prescription form when a controlled substance is prescribed or otherwise requested.

The CNM may obtain approval to dispense those drugs and devices included in the written clinical practice guidelines for each practice site from the Board of Pharmacy, and must carry out the function of dispensing in accordance with Section .1700 of Title 21 NCAC Chapter 46.

NURSE-MIDWIFE APPLICATION INSTRUCTIONS

IMPORTANT NOTICE

If you submit an application, please be sure that it is typewritten or legibly written in **BLACK** ink, that you include all information required. Please be sure your practice name, address, including zip code, are consistent with other CNMs in the same practice. We do use data from our records for mailing lists (non-commercial) and reports requested throughout the year.

If you do not have a home address in NC please be sure to notify the NC Board of Nursing and the Midwifery Joint Committee in writing when this is available. This provides important information and allows you to receive appropriate mailings.

I. **INITIAL APPLICATIONS FOR APPROVAL AS CERTIFIED NURSE MIDWIFE/APPLICANT**

(first N.C. employment as CNM) Initial applications are reviewed and approved by the Midwifery Joint Committee. Written notification of the Committee's action will be mailed to the nurse midwife's home address.

- A. Mail to: **Midwifery Joint Committee, P. O. Box 2129, Raleigh, NC 27602-2129.**
- B. Completed application forms must be typewritten or can be printed in **BLACK** ink. The forms will be returned if not complete.
- C. Include the following with your completed application:
 - (1) Photocopy of certification from the American College of Nurse-Midwives.
 - (2) Application fee of \$100.00 made payable to the **Midwifery Joint Committee** must be attached to the application form when submitted and is non-refundable.

II. **SUBSEQUENT APPLICATIONS FOR APPROVAL**

In general the following applications will be processed and administratively approved by Committee's staff. However, administrative approval is not automatic and an application may need to be referred to the Committee for review.

- Change in practice arrangement (a change in practice site and primary physician for a CNM) **(\$100.00)**
 - Additional practice arrangement (additional arrangement with additional primary physician other than the practice arrangement already approved) **(\$100.00)**
 - Notification of change in primary supervising physician in currently approved practice arrangement **(NO FEE)**
- A. Mail to: **Midwifery Joint Committee, P. O. Box 2129, Raleigh, NC 27602-2129.**
 - B. Completed application must be printed in **BLACK** ink or typewritten. The forms will be returned if not complete.
 - C. Enclose the appropriate application fee made payable to the **Midwifery Joint Committee**, which must be attached to the application form when, submitted and is non-refundable.

WHEN ANY CHANGES OCCUR IN YOUR PRACTICE SITUATION, NOTIFY THE MIDWIFERY JOINT COMMITTEE IN WRITING AND MAIL TO:

**MIDWIFERY JOINT COMMITTEE
P. O. BOX 2129
RALEIGH, N C 27602-2129**

MIDWIFERY JOINT COMMITTEE
APPLICATION FOR APPROVAL OF CERTIFIED NURSE-MIDWIFE

IMPORTANT INSTRUCTIONS

PLEASE PRINT IN BLACK INK OR CAN
BE TYPEWRITTEN.

TYPE OF APPLICATION (Check One)

___ Initial CNM employment in NC (**\$100.00**)
[Complete Form Titled: LICENSURE BIOGRAPHY
FROM OTHER STATES, if previously employed
as CNM in other state(s).]

___ Nurse Midwife Applicant (**\$100.00**)
(Certification Pending)

___ Subsequent Application(s)

___ Practice Change within NC (**\$100.00**)

___ Additional Practice with Additional Supervising Physicians(s) within NC (**\$100.00**)

___ Notification of change of primary supervising physician within current practice arrangement
(**NO FEE**)

STAFF USE ONLY

___ Date Form Received
___ RN License Verified
___ NC CNM # Verified
___ MD Licenses Verified
___ ACNM Certification
Verified
___ Fee Received

I. CNM APPLICANT INFORMATION

A. SS# ___/___/___ Date of Birth ___/___/___
ACNM # _____ NC CNM # _____
Applicant (full-name) _____
(First) (Middle) (Maiden) (Last)
Home Address _____
(Street) (City) (State) (Zip Code)
* Primary State of Residence _____ Licensed Issued by State/US Possession _____
RN Certificate/License Number _____ Expiration Date _____
Practice Name _____
Practice Address _____
(Physical Location) (Street) (City) (State) (Zip Code)
If Different From Above:
Practice Mailing Address _____
(Street) (City) (State) (Zip Code)
Telephone # (Office) _____ (Home) _____

INSTRUCTIONS:

Photograph requested
for initial application
and re-application
after inactive period.

Intapp
Adopted 6/10/85
Revised: 12/85; 11/93; 11/96;
1/00; 6/00; 7/00

GLUE OR PASTE

Durable Passport-Type
Photograph
(Not Over 6 Months Old)

Polaroid Photos
NOT Acceptable

I certify this is a
photograph of myself
taken within the past
six (6) months.

Signature

* **NOTE:** If your primary state of residence is **NOT** a compact state, a North Carolina registered nurse license is required.

TYPE OF PRACTICE SETTING (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> County Health Department | <input type="checkbox"/> Physician or Group Medical Practice |
| <input type="checkbox"/> Hospital – In-patient | <input type="checkbox"/> Medical School or Nursing School |
| <input type="checkbox"/> Hospital – Out-patient | <input type="checkbox"/> HMO |
| <input type="checkbox"/> Free-Standing Birthing Center | |
| <input type="checkbox"/> Publically-funded Clinic (not a Health Dept.) | |
| <input type="checkbox"/> Other (Specify) _____ | |

Is your position funded with public money? ___ No ___ Yes. If yes, please check the funding sources that apply: ___ Federal ___ State ___ City ___ County.

What percentage of your clinical practice time will be spent delivering?

- _____ Primary care
- prenatal care and postpartum care
 - intrapartum care
 - well woman gynecology/family planning/treatment of common medical disorders
 - newborn care

- _____ Specialized Care
- Infertility
 - Oncology
 - Other (Specify) _____

_____ Other (Specify) _____

B. **EDUCATION** (Give location, attendance dates, and degree or certificate earned)

(1) Midwifery Education _____

Address _____
(City) (State)

Degree/Certificate _____ Year of Completion _____

(2) **HIGHEST ACADEMIC DEGREE HELD: Check Appropriate Box**

- | | | | |
|----------------------------------|-------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Diploma | <input type="checkbox"/> ADN | <input type="checkbox"/> BS | <input type="checkbox"/> BSN |
| <input type="checkbox"/> MS | <input type="checkbox"/> MSN | <input type="checkbox"/> MPH | <input type="checkbox"/> Ed.D. |
| <input type="checkbox"/> Ph.D. | <input type="checkbox"/> DrPh | <input type="checkbox"/> Other _____ | |

C. **PREVIOUS CNM EMPLOYMENT**

Have you been approved to practice as a Certified Nurse Midwife in another state?

- Yes No

If yes, please list below all states in which you have been approved and complete the enclosed page titled LICENSURE BIOGRAPHY - FROM OTHER STATES (Page 8) regarding certified nurse midwife employment in other states. You must forward to the appropriate state for verification one form for each state where you have been approved to practice as a CNM. Any applicable fees are the applicant's responsibilities.

CNM APPLICANT BACKGROUND

Please circle the answers to the following questions. If you answer "YES" to any of questions 1-4, give a detailed explanation on attached **BACKGROUND FORM (Page 6)**. If you answered "YES" to question 5, please complete the enclosed form titled **CLAIMS INFORMATION FORM (Page 7)**.

- | | | | |
|-----|----|----|---|
| YES | NO | 1. | Have you ever been convicted of or plead guilty to a violation of a federal, state, or local law other than minor traffic violations? |
| YES | NO | 2. | Have any formal disciplinary proceedings ever been filed against you by a licensing board? |
| YES | NO | 3. | Have you ever surrendered, relinquished, or permitted the lapse of any approval issued to you as a nurse-midwife in any jurisdiction? |
| YES | NO | 4. | Have you ever entered into any formal consent order, consent agreement, or any other restrictive arrangement with a licensing board or regulatory agency in any jurisdiction? |
| YES | NO | 5. | Have you ever been a defendant in a legal action involving professional liability (malpractice), have you ever been named in a malpractice suite, had a professional liability claim paid on your behalf, or paid such a claim on yourself? |

CNM Signature

Date

II. LOCATIONS WHERE CNM WILL PRACTICE

CNM PRACTICE LOCATIONS. As part of this specific practice arrangement, list ALL locations where the CNM applicant will provide midwifery services. Include name of practice site, physical location (street, city, zip code).

V. CERTIFICATION OF UNDERSTANDING AND COMPLIANCE

The below named certified nurse-midwife and the below named primary supervising physician, the physician being actively engaged in the practice of obstetrics/gynecology, have adopted the Standards of Nurse-Midwifery Practice (ACNM) which include mutually agreed upon written clinical practice guidelines for clinical practice and for ongoing communication regarding those guidelines. We agree to periodic and joint evaluation of services rendered. We agree to have these clinical practice guidelines signed by the certified nurse-midwife and the primary supervising physician and back-up supervising physician(s) and will be maintained at each practice site. We support the concept that quality of care is enhanced by the interdependent practice of the physician and the certified nurse-midwife working in a relationship of mutual respect, trust, and professional responsibility. This does not necessarily imply the physical presence of the physician when care is being given by the certified nurse-midwife. We have jointly developed and signed protocols which include those drugs and devices that may be prescribed or ordered by the certified nurse midwife in accordance with G.S. 90-18.2(b) and Administrative Rule 21 NCAC 36.0227(h) and 21 NCAC 32M.0006(c).

Each of the undersigned has read this application and certifies that the information contained herein is correct to the best of his/her knowledge and belief. Each further certifies that she/he has read and understands the North Carolina statutes and rules adopted by the Midwifery Joint Committee of North Carolina governing the practice of midwifery and agrees to comply with the same.

Date _____

X _____ MD/DO
Primary Supervising Physician Signature

(Type or legibly print MD/DO Name)

Date _____

X _____ CNM
Certified Nurse Midwife Applicant Signature

(Type or legibly print CNM Name)

CNM APPLICANT OR SUPERVISING PHYSICIAN

BACKGROUND FORM

Completed by: CNM or MD/DO

Print Name: _____

Provide detailed explanation of any "YES" answers to background questions 1-4 on page **3** by the CNM applicant or questions 1-4 on Page **4** by the primary supervising physician(s). Please photocopy this form if additional space is needed.

NOTE: This form must be co-signed by both the CNM applicant and the primary supervising physician.

Date

Signature of CNM Applicant

Date

Signature of Supervising MD/DO

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[CHECK CORRECT DESIGNATOR]

CNM

MD/DO

CLAIMS INFORMATION FORM

The CNM applicant or primary supervising physician(s) must complete this form for each liability or malpractice claim of which either is aware. Please make as many photocopies of this form as you will need. Complete one form for each claim or suit. Signatures of both the CNM applicant and the primary supervising physician are required on each completed form.

1. Describe briefly the details of the allegations against you. Include the patient's name, a brief history, comments regarding the examination and care surrounding the allegations. If suits are pending a very brief summary of the allegations or charges must be included regardless of the litigation stage. Simply stating that the charges were dismissed is inadequate.

2. Date of the claim: _____

3. If an insurance carrier was involved, list the name, address and telephone number:

4. Is the claim pending? Yes No

5. Was there a judgment or settlement? Yes No

6. What was the amount and date of the judgment **OR** settlement?

Amount _____

Date _____

7. Comments: _____

I certify that the information which I have given is correct to the best of my knowledge.

Signature/Title of Person Completing Form

Date

Co-Signature/Title of CNM Applicant or
Supervising MD

Date

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LICENSURE BIOGRAPHY - FROM OTHER STATES

Complete the top portion of this form and forward one copy to each licensing board in states where you have held or do hold certified nurse-midwife approval/license. To insure immediate response, enclose a stamped envelope addressed to: **Midwifery Joint Committee, P. O. Box 2129, Raleigh, N.C. 27602-2129**. The fee is the applicant's responsibility. Please make as many copies of this form as are needed.

I am applying for approval as a Certified Nurse Midwife in North Carolina.

I was granted approval # _____ on _____ by the State of _____

The Midwifery Joint Committee requires information regarding my approval/license. This is my request for you to respond to the questions below and also gives you authority to release any information, favorable or otherwise, to the North Carolina Midwifery Joint Committee.

Printed or Typed Name

Signature

Social Security Number

Address

Date of Birth

STATE LICENSING AGENCY COMPLETING FORM:

Please complete and return this form to: **Midwifery Joint Committee, P. O., Box 2129, Raleigh, NC 27602-2129**.

This is to certify that the records of the _____ Board of Nursing or Medical Board indicate that _____ CNM was issued license/approval number _____ on _____, 19 ____ as a certified nurse-midwife in the state of _____.

Respond to the following questions.

- | | | | |
|----|---|-----|----|
| 1. | Is this license current ? | YES | NO |
| 2. | Is this license in good standing? | YES | NO |
| 3. | Have any charges ever been <u>filed</u> against this CNM? | YES | NO |
| 4. | Do you know of any information that may discredit this person? | YES | NO |
| 5. | Do your files indicate any derogatory information? | YES | NO |
| 6. | Have you received any complaints against this CNM? | YES | NO |
| | | | |
| 7. | Has this CNM been investigated by your Board? | YES | NO |
| 8. | Have you received any information about this CNM from the
National Practitioner Data Bank? | YES | NO |

If "YES" answered to questions #3-8, please attach an explanation.

Authorized Signature of Individual Completing Form

Date