New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Midwifery Liaison Committee
140 East Front Street, 2nd Floor, P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Midwifery Liaison Committee
Application Checklist

Use this checklist to determine whether you have complied with all of the requirements. Once your application has been received, a file will be established and you will be notified regarding any missing documents or fees.

- ☐ Three (3) passport-size photographs.
- ☐ A nonrefundable application fee of $125.00 made payable to the ***State of New Jersey***.
- ☐ An additional nonrefundable application fee of $50.00 made payable to the ***State of New Jersey, only*** if you are also applying for Prescriptive Authorization.
- ☐ A copy of your birth certificate, passport or proof of your immigration status.
- ☐ A completed and notarized application.
- ☐ Official midwifery education transcripts requested to be sent ***directly*** to the Committee at: Midwifery Liaison Committee, P.O. Box 183, Trenton, New Jersey 08625.
- ☐ Official verification of your certification status to be sent from one of the following: the American Midwife Certification Board (A.M.C.B.), the American College of Nurse Midwives Certification Council (A.C.C.), or the North American Registry of Midwives (N.A.R.M.), as applicable. The form should be sent ***directly*** to the Committee at: Midwifery Liaison Committee, P.O. Box 183, Trenton, New Jersey 08625.
- ☐ If you are applying for Prescriptive Authorization and have completed your pharmacology education in a program separate from your midwifery education, an authorized representative of the program should complete the verification form attached to the application.
- ☐ A completed and notarized Certification and Authorization Form for a Criminal History Background Check (C.H.B.C.). Instructions for the completion of a C.H.B.C. will be provided once your application has been received. If you have been fingerprinted by another New Jersey licensing board (such as the Board of Nursing), please read the instructions carefully. You do not have to be fingerprinted again. If your fingerprints were completed within the last six months, your federal background check does ***not*** need to be repeated and you should ***not*** submit an additional check for $17.50.
- ☐ Your resume or curriculum vitae.
- ☐ The Verification of License form sent to the Committee office from any and/or all states in which you hold ***any*** professional license. Copies of licenses are ***not*** considered adequate verification for this purpose. You may use the attached verification form or the issuing state may have its own form.

Please take note of the fact that certain responses to some of the questions may require you to submit additional explanatory information. Please attach any explanations to your application. Please make reference to the number of the question to which you are responding.

Apply here one clear, full-face passport-style photograph (2″x 2″) of your head and shoulders, taken within the past six months.

Attach two additional passport-style photos to this application.

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For office use only

Application number: _____

License number: _____

License issue date: _____

Application for Licensure as a Midwife

Date : _____

I am applying for a license as a:

☐ Certified Nurse Midwife
☐ Certified Professional Midwife
☐ Certified Nurse Midwife with Prescriptive Authority
☐ Certified Midwife

A nonrefundable application filing fee of $125.00, in the form of a check or money order made out to the State of New Jersey, must be submitted with this application (applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid).

The Division is precluded by law from disclosing to the public the place of residence of licensees or applicants, without their consent. However, you are required to provide an address that may be released to the public in our directories or in response to other requests (by putting a check in the appropriate box). If you provide your place of residence as your public address of record, we will assume that you have consented to have that address be disclosed. If you do not consent to the disclosure of your place of residence, you should provide an address of record other than your place of residence that may be released to the public. One of your addresses must include a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

Date of birth: _____
Month Day Year

Place of birth: _____
City State Country

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
Last name First name Middle initial Maiden name

2. Address

☐ Home: _____
Street or P.O. Box City State ZIP code County

_____ _____
Telephone number (include area code) E-mail address

☐ Business: _____
Name of company Telephone number (include area code)

_____
Street City State ZIP code County

☐ Mailing: _____
Street or P.O. Box City State ZIP code County

3. Social Security Number

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in denial/nonrenewal of licensure or certification.

*Social Security Number: _____ -_____ - _____

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7,60.8 and 60.9, the Board or Committee is required to obtain your Social Security number. Pursuant to these authorities, the Board or Committee is also obligated to provide your Social Security number to:

a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;

b. the Probation Division or any other agency responsible for child-support enforcement, upon request; and

c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are an American citizen, please enclose a copy of your birth certificate or U.S. passport. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐ Yes ☐ No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual repayment of the loan. You will not be able to obtain a license unless you provide the required documents concerning the plan for repayment of your student loan.

6. Child Support **(You must answer a, b, c and d.)**

Please certify, under penalty of perjury, the following:

a. Do you currently have a child-support obligation? ☐ Yes ☐ No

(1) If "Yes," are you in arrears in payment of said obligation? ☐ Yes ☐ No

(2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months? ☐ Yes ☐ No

b. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No

c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No

d. Are you the subject of a child-support-related arrest warrant? ☐ Yes ☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

_____	_____	_____
Applicant's name (please print)	Applicant's signature	Date

7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

"Ability to practice your profession" is to be construed to include all of the following:

a. The cognitive capacity to exercise the reasonable judgments of a midwife, and to learn and keep abreast of professional developments; and

b. The ability to communicate those judgments and related information to patients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform the duties of a midwife, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

"Chemical substance" 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.

"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 may have an ongoing impact on one's functioning as a licensee, or within the previous two years.

"Illegal use of controlled dangerous substance" means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

a. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**?
☐ Yes ☐ No ☐ Not applicable

c. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? ☐ Yes ☐ No ☐ Not applicable

d. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No ☐ Not applicable

e. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
☐ Yes ☐ No

f. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") ☐ Yes ☐ No

If you answered "Yes" to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☐ No

** If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individualized 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 or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

_____ Signature of applicant

_____ Date

8. Have you ever changed your name? ☐ Yes ☐ No
If "Yes," please submit with this application a copy of the marriage certificate, divorce decree or court order.

9. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

10. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

11. Have you served in the Armed Forces of the United States? ☐ Yes ☐ No
If "Yes,"what type of military discharge did you receive? Indicate the type of discharge you received.

_____

12. Do you currently hold, or have you ever held, a professional or occupational license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction?

☐ Yes ☐ No

If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license was issued under a different name, please provide that name.

_____
Last name First name Middle initial

Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired

13. Have you ever taken any other state board or regional board's exam and failed? ☐ Yes ☐ No
If "Yes,"please provide the name of the state and the date the exam was taken.

_____ State _____ Date

14. Have you ever been cited for disciplinary reasons or denied a professional or occupational license or certificate of any kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Have you ever had a professional or occupational license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Has any action (including the assessment of fines or other penalties) ever been taken against your professional or occupational practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction?

☐ Yes ☐ No

17. Have you ever been named as a defendant in any litigation related to the practice of midwifery or other professional or occupational practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction?

☐ Yes ☐ No

18. Are you aware of any investigation pending against a professional or occupational license or certificate issued to you by a professional or occupational board in New Jersey, any other state, the District of Columbia or in any other jurisdiction?

☐ Yes ☐ No

19. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

20. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional or occupational group related to the practice of midwifery or other professional or occupational practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

If the answer to any of the above questions, numbers 14 through 20, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Education

Name and address of institution_____
Name of institution

_____
Street address City State ZIP code

Date enrolled _____ ☐ Completed program on _____

An official transcript from a midwifery program accredited by the American College of Nurse Midwives (A.C.N.M.) or the Midwifery Education Accreditation Council (M.E.A.C.) or their successor organizations, must be forwarded directly to the Committee's office.

Please submit a resume or curriculum vitae listing all activities including periods of unemployment beginning with graduation from high school through the present time.

Certification Examinations

Please indicate exam taken: ☐ A.C.N.M. / A.M.C.B. ☐ A.C.C. ☐ N.A.R.M.

Date of certification _____

An official notarized copy attesting to an applicant's certified status must be provided by the certification organization directly to the Committee's office.

Prescriptive Authorization

New Jersey requires that applicants complete their pharmacology education within two years from the date of application (or as part of your midwifery education), or hold a current prescriptive authorization in another state. If you are not applying for prescriptive authorization, skip this question and move on to the next.

Do you hold prescriptive authorization in any other state? ☐ Yes ☐ No

If the answer is "Yes," the issuing state must submit a Verification of State License form (attached) indicating that the prescriptive authorization is current and in good standing.

State that issued the license	License number	Date issued/expired	Status

The verification form must be sent directly from the state(s) to the Midwifery Liaison Committee. In lieu of completing the attached form, the Committee will accept a state-issued verification letter.

Pharmacology Education

Please complete this section if your pharmacology education was completed in a program other than your midwifery program. The program must have consisted of at least 30 contact hours and be accredited college or university-based or affiliated.

Name and address of institution_____
Name of institution

_____
Street address City State ZIP code

Date enrolled _____ ☐ Completed program on _____

Affidavit

This affidavit is to be executed by the applicant before a notary public:

State of:_____

County of:_____ } *ss.*

I, _____ , in making this application to the Midwifery Liaison Committee for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the Midwifery Liaison Committee, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Committee.

I further swear (or affirm) that I have read N.J.S.A. 45:10-1 et seq., together with the Rules and Regulations of the Midwifery Liaison Committee, N.J.A.C. 13:35-2A.1 et seq., and fully understand that in receiving licensure or certification from the Committee, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Committee.

_____
Signature of applicant

Sworn and subscribed to before me this_____

day of _____ , _____
Month Year

Affix seal here

_____
Name of Notary Public (please print)

_____
Signature of Notary Public

Authorization to Release Records

I, _____ , hereby authorize all hospitals*, institutions* or organizations, my references, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the State Board of Medical Examiners' Midwifery Liaison Committee any information, files or records requested by the Board. I further authorize the State Board of Medical Examiners' Midwifery Liaison Committee to release to the organizations, individuals and groups listed above any information.

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

I have read the above and understand the same.

_____
Date

_____
Applicant's name (Please print)

_____
Applicant's signature

Sworn and subscribed to before me this_____

day of _____ , _____
Month Year

_____
Name of Notary Public (please print)

_____
Signature of Notary Public

Affix seal here

*relating to clinical or postgraduate programs

If you require additional space to answer any of the preceding questions, you may attach your response(s) on separate sheets of paper to the last page of this application, having made sure that you print or type your name and the number of the question to which you are responding on each of the attachments.

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(609) 826-7100

Verification of State License

A separate form must be used for each state.
(This form may be reproduced.)

Please print clearly.

Name of applicant_____
Last name First name Middle initial

The above-named applicant is a licensee of the State of _____ and was issued license number _____ on_____ .
Month / Day / Year

The applicant was licensed by:

☐ Examination

☐ Endorsement / Reciprocity from the State of _____ .

The license status is:

☐ Current and in good standing expiring on _____ . ☐ Revoked or Suspended
Date

☐ Inactive / Expired on_____ . ☐ Other (Please attach an explanation.)
Date

This licensee ☐ does ☐ does not hold prescriptive authority in this State.

This licensee ☐ does ☐ does not have a record of disciplinary history with this agency.
(Attach additional information if applicable.)

Certification

I hereby certify that to the best of my knowledge and belief, the foregoing is a true statement of the record of the individual named on this form.

_____
Date

_____
Name of Board

_____
Name of person completing this form

Affix Board seal here

_____
Title

_____
Signature

Official Use Only
☐ Dual License
License Type 1
_____
Applicant's Number
_____
License Type 2
_____
Applicant's Number
_____

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Midwifery Liaison Committee
P.O. Box 46018
Newark, New Jersey 07101
(973) 273-8009

Official Use Only
☐ Resubmit
_____
Board or Committee
_____

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name

2. Address _____
   Street or P.O. Box City State ZIP code

3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year

4. Social Security number _____/ _____ / _____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history record background check process. No payment is necessary as of now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is $17.50.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

Certification

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date

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Verification of Pharmacology Education

Please print clearly.

Name of applicant_____
Last name First name Middle initial

Course title_____

Address_____
Street address City State ZIP code

Hours completed_____ Dates _____

It is hereby certified that the above-named Certified Nurse Midwife has successfully completed a minimum educational program of at least 30 contact hours, as defined by the National Task Force on the Continuing Education Unit, in the course identified above on the date shown. This individual received full credit from the organization for the course shown.

_____
Date

_____
Signature

_____
Title of certifying official

Note

This form must reflect the seal of the organization sponsoring the course. A copy of the course's syllabus must be attached to the form unless the course has been previously approved by the Committee.

Return this form to the address noted above.