

**Regular Mailing Address**  
**STATE BOARD OF MEDICINE**  
 P.O. BOX 2649  
 HARRISBURG, PA 17105-2649  
 717-783-1400/717-787-2381  
 Email: [st-medicine@pa.gov](mailto:st-medicine@pa.gov)

**Courier Delivery Address**  
**STATE BOARD OF MEDICINE**  
 2601 NORTH THIRD STREET  
 HARRISBURG, PA 17110

## INITIAL APPLICATION FOR A NURSE-MIDWIFE LICENSE

1. **This license class does not include prescriptive authority.** If you wish to hold a certificate for prescriptive authority, you must be able to meet the requirements to obtain prescriptive authority and complete the Initial Application for Nurse-Midwife Prescriptive Authority.
2. In addition to completing this application, **you will also need to register a collaborative agreement with the Board.** You may not practice midwifery until a collaborative agreement has been registered with the Board.

### REQUIREMENTS FOR LICENSURE:

1. Hold an active Pennsylvania Registered Nurse license.
2. Successful completion of a midwifery program.
3. Successfully pass the national certification exam administered by the American Midwifery Certification Board, Inc.
4. The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. [Child Abuse Continuing Education Providers Information can be found here.](#)

**PLEASE NOTE:** If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.

### APPLICANTS MUST COMPLETE THE FOLLOWING:

1. Submit the \$50.00 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** **Check or money order must be in "US funds."** **Note:** A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.
2. Complete pages 1 and 2 of the application.

3.	If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.).
4.	Complete Section 1 of the Certification of Midwifery Education form and send to the midwifery program where you completed your education. Section 2 should be completed by the school/program. <b>The midwifery program must return the completed form directly to the Board in an official school envelope.</b>
6.	Contact the American Midwifery Certification Board, Inc., and arrange for the verification of certification to be sent directly to the Board office in an official envelope.
7.	Contact the state board office(s) where you hold or have ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation and request letters of good standing. The letter must include the following: license issue and expiration date, license status (current or expired) and disciplinary standing. The letter(s) of good standing must be sent directly to the Board.
8.	Attach a Curriculum Vitae listing <b>all</b> periods of employment or unemployment (i.e. child rearing, research, etc.) from graduation from midwifery school to date. The list must be in chronological order, include the month and year and indicate the state/territory in which the employment occurred.
9.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank. Please refer to the NPDB website for additional information. When you receive the "Response to your Self Query," forward the entire report directly to the Board Office. <u>You should make a copy for your records.</u>
10.	Complete the form entitled Initial Collaborative Agreement for Nurse-Midwife License (see attached). This form may be submitted separately from the Initial Application for a Nurse-Midwife License. Original signatures are required.

### IMPORTANT INFORMATION

1.	<b>PLEASE FOLLOW ALL DIRECTIONS. ANY DISCREPANCIES WILL CAUSE A DELAY IN THE ISSUANCE OF A LICENSE.</b>
2.	<b>IF THIS APPLICATION IS NOT COMPLETED WITHIN SIX MONTHS, <u>UPDATES OF CERTAIN SECTIONS AND/OR SUPPORTING DOCUMENTS WILL BE REQUIRED.</u></b>
3.	<b>IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO THE BOARD OR RECEIVED FROM THE BOARD.</b>
4.	<b>YOU MAY NOT PRACTICE THIS PROFESSION IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL THE PENNSYLVANIA STATE BOARD OF MEDICINE HAS ISSUED A LICENSE AND A COLLABORATIVE AGREEMENT HAS BEEN REGISTERED WITH THE BOARD.</b>
5.	<b>IN ORDER TO PRACTICE THIS PROFESSION IN THE COMMONWEALTH OF PENNSYLVANIA, YOU MUST MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE COVERAGE.</b>
6.	<b>ALL NURSE-MIDWIFE LICENSES WILL EXPIRE DECEMBER 31<sup>ST</sup> OF AN EVEN-NUMBERED YEAR. THE EXPIRATION DATE IS NOT DETERMINED BY THE ISSUE DATE.</b>
7.	<b>THE FEE SUBMITTED WITH THIS APPLICATION IS A PROCESSING FEE. AT RENEWAL TIME, YOU WILL BE ASSESSED THE FULL RENEWAL FEE.</b>
8.	<b>IF THE APPLICATION PROCESS IS NOT COMPLETED WITHIN ONE YEAR, APPLICANTS WILL BE REQUIRED TO SUBMIT AN UPDATED APPLICATION (<u>ANOTHER APPLICATION PROCESSING FEE</u>) ALONG WITH SUPPORTING DOCUMENTS, AS NECESSARY.</b>

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### TO BE COMPLETED BY APPLICANT (Please print or type)

<b>NAME:</b>	Last	First	Middle
<b>ADDRESS:</b>	Street		
City	State		ZIP
<b>DATE OF BIRTH:</b>	Month	Day	Year
<b>SOCIAL SECURITY NUMBER:</b>			
<b>PA REGISTERED NURSE LICENSE NO:</b>			
<b>PHONE NUMBER:</b>			
<b>EMAIL ADDRESS:</b>			
If your supporting documents are listed under another name or names, please list below:			
<hr/> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Last</span> <span>First</span> <span>Middle</span> </div>			
<b>NAME &amp; ADDRESS OF MIDWIFERY SCHOOL</b>			
<b>NAME OF MIDWIFERY SCHOOL:</b>			
<b>ADDRESS OF SCHOOL:</b>			
<b>DATES OF ATTENDANCE:</b>	<b>FROM</b>	Month	Day
			Year
	<b>TO</b>	Month	Day
			Year
<b>DATE OF GRADUATION:</b>	Month	Day	Year

## LEGAL QUESTIONS

**You must answer the following questions.** If you answer "YES" to #2 through #12, provide complete details on a separate sheet as well as certified copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? <b>If you answered yes, provide the profession and state or jurisdiction.</b> <b>LIST:</b> _____		
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
8	Have you had your DEA registration denied, revoked or restricted?		
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11	Have you engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
12	Have you been the subject of a civil malpractice lawsuit? <b>If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.</b> <b>**If you previously reported the complaint to the Board provide the docket number</b> _____		

## SIGNED STATEMENT

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant

**PENNSYLVANIA STATE BOARD OF MEDICINE**

**CERTIFICATION OF MIDWIFERY EDUCATION**

Complete Section 1 of this page and forward to the college or university where you completed your midwifery education.

**SECTION 1 – TO BE COMPLETED BY APPLICANT**

<b>NAME:</b>	Last	First	Middle
<b>ADDRESS:</b>	Street		
City	State	ZIP	
<b>NAME OF MIDWIFERY SCHOOL:</b>			
<b>ADDRESS:</b>	Street		
City	State	ZIP	

Submit the certification of midwifery education form to your school and request the school return the completed form directly to the board in an official school envelope.

**SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MIDWIFERY SCHOOL**

<b>NAME OF MIDWIFERY SCHOOL:</b>			
<b>NAME OF STUDENT:</b>	Last	First	Middle
<b>DATE STUDENT BEGAN TO ATTEND THIS MIDWIFERY SCHOOL:</b>	Month	Day	Year
<b>DATE OF GRADUATION:</b>	Month	Day	Year

**I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT**

<b>SIGNATURE OF DEAN, REGISTRAR OR OFFICIAL OF AN ACCREDITED INSTITUTION OF HIGHER EDUCATION:</b>			
<b>DATE:</b>	Month	Day	Year
(Seal of School)	<p>Upon completion, the school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.</p> <p align="center"><b><i>DO NOT RETURN THIS FORM TO THE APPLICANT</i></b></p>		

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## INITIAL COLLABORATIVE AGREEMENT FOR NURSE-MIDWIFE LICENSE

### IMPORTANT APPLICATION INFORMATION

1. This application is only used for entering into the first nurse-midwife collaborative agreement. A separate collaborative agreement must be submitted for each physician, physician group or service with which you will be entering into an agreement. A new application is required for each additional collaborative agreement. To register additional collaborative agreements, complete the application titled, **Additional Collaborative Agreement for Nurse-Midwife License**. If making changes to an existing collaborative agreement, complete and submit the **Collaborative Agreement Change Form**.
2. This application may be used to enter into a collaborative agreement with an allopathic or osteopathic physician licensed by the State Boards of Medicine or Osteopathic Medicine. The physician must have hospital privileges (or a formal arrangement for patient admission to a hospital) and shall practice in the specialty area of the care for which the physician is providing collaborative services. **This collaborative agreement will NOT include prescriptive authority privileges.**
3. **A copy of the collaborative agreement must be submitted with this application.**
4. Pennsylvania law requires you to maintain a copy of this application as well as your collaborative agreement.

**YOU MAY NOT PRACTICE UNDER THIS COLLABORATIVE AGREEMENT UNTIL THE REGISTRATION IS COMPLETE AND FILED WITH THE BOARD.**

### PLEASE PRINT OR TYPE

<b>NURSE-MIDWIFE NAME:</b>	Last	First	Middle
<b>NURSE-MIDWIFE LICENSE NO:</b>			
<b>COLLABORATING PHYSICIAN NAME:</b>	Last	First	Middle
<b>PHYSICIAN LICENSE NO:</b>			
<b>This agreement contains the details of the collaborative arrangement between myself and the below-signed collaborating physician with respect to the care of midwifery patients.</b>			
<b>NURSE-MIDWIFE SIGNATURE:</b>			Date
<b>This agreement contains the details of the collaborative arrangement between myself and the above-signed nurse-midwife with respect to the care of midwifery patients.</b>			
<b>COLLABORATING PHYSICIAN SIGNATURE:</b>			Date