Total Due: $137.00 in U.S. funds ($105.00 application fee and $32.00 criminal background check fee) if a background check has not been completed within the last year with the Minnesota Board of Nursing. Money order or cashier's check only. No personal checks. All fees are nonrefundable.
Total Due: $105.00 in U.S. funds ($105.00 application fee) if a background check has been completed within the last year with the Minnesota Board of Nursing. Money order or cashier's check only. No personal checks. All fees are nonrefundable.

MINNESOTA BOARD OF NURSING

1210 Northland Drive #120, Mendota Heights, MN 55120
Voice: 612-317-3000 | Fax: 651-688-1841 |TTY: 800-627-3529
Toll Free (MN, IA, ND, SD, WI): 888-234-2690
Email: nursing.board@state.mn.us
Website: mn.gov/boards/nursing

LICENSED CERTIFIED MIDWIFE APPLICATION

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements. Minnesota Statute Sec. 270C.72 requires applicants to provide their Social Security number and Minnesota business identification number on all license applications.

Until you are issued a license, all data submitted on the application, except your name and address, are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the application, except social security number and responses to grounds for review questions, becomes public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

- **Type or print clearly**
- **Provide all information**
- **Incomplete forms will be returned**
- **Do not use initials or abbreviations**

APPLICANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
EMAIL ADDRESS		
BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female ☐ Non-Binary	
UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72 ___ - ___ - ____	☐ I do not have a US Social Security number at this time but will notify the Board if/when I obtain a US Social Security number.	MINNESOTA BUSINESS IDENTIFICATION NUMBER Required by Minn. Stat. Sec. 270C.72
GRADUATE-LEVEL MIDWIFERY EDUCATION PROGRAM NAME		COMPLETION DATE (mm/dd/yyyy)

If it has been more than five years since you practiced as a certified midwife, you will need to complete a Board approved reorientation plan upon licensure. Please contact the Minnesota Board of Nursing for more information.

LAST DATE OF PRACTICE AS CERTIFIED MIDWIFE (mm/dd/yyyy)

BUSINESS ADDRESS: Minn. Stat. Sec. 214.073 requires licensees to provide their primary business address (if employed as a certified midwife) at the time of initial application and all renewals. Your license will not be issued unless you provide it or check the box below certifying that you are not currently in the workforce related to your practice.

BUSINESS NAME (if employed as a certified midwife)		
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE

☐ I certify that I am not currently in the workforce related to my practice and I don't have a business address related to my practice.

-OVER-

CURRENT CERTIFICATION

Applicant must request documentation of current certification in good standing from the American Midwifery Certification Board be sent by mail to the Minnesota Board of Nursing at 1210 Northland Drive Suite 120, Mendota Heights, MN 55120 or email to nursing.board@state.mn.us. The certification must be received directly from the certifying body to the Board.

PRESCRIBING

DEA NUMBER	STATE ISSUED
☐ I do not have a DEA number	

GROUNDS FOR DENIAL

Provide a written explanation for every YES response.

1.	☐ Yes ☐ No	Have you ever violated a state or federal law or rule relating to the practice of midwifery in any state, territory or country?
2.	☐ Yes ☐ No	Have you ever violated a state or federal law or rule relating to narcotics or controlled substances or other similar regulations?
3.	☐ Yes ☐ No	Have you ever been convicted, entered a plea of guilty, nolo contendere, or no contest, for any felony, gross misdemeanor or misdemeanor offense? NOTE: The fact that a conviction has been pardoned, dismissed, stayed, or deferred, or that your civil rights have been restored, does not mean that you answer "NO"; you should answer "YES."
4	☐ Yes ☐ No	Are there currently any pending criminal charges against you in any jurisdiction for felony, gross-misdemeanor, or misdemeanor crimes? NOTE: If charges have been dismissed or resulted in a disposition disclosed in the prior question you may answer "NO."
5.	☐ Yes ☐ No	In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent?
6.	☐ Yes ☐ No	In the last five years of midwife-related employment, has any employer investigated, disciplined or terminated you for conduct that may be grounds for disciplinary action under the Minnesota Certified Midwife Practice Act?
7.	☐ Yes ☐ No	Have you ever been under investigation or been the subject of any pending or past disciplinary action involving your midwifery practice or any occupational license in any state, territory or country?
8.	☐ Yes ☐ No	Do you have any physical or mental disability or illness that currently impairs your ability to practice midwifery with reasonable skill and safety? **Provide a statement explaining management and treatment**. NOTE: If you are currently participating in the Health Professionals Services Program (HPSP) for this illness, you may answer "NO" to this question
9.	☐ Yes ☐ No	Have you ever received notification from the Minnesota Department of Human Services or the United States Department of Health and Human Services, Office of the Inspector General that you have been disqualified from providing direct care or excluded from participation in Medicare or Medicaid?

I affirm that the statements and documents provided by me during the application process are true and correct.

Legal Signature of Applicant _____ Date _____

Return completed form and fees to Minnesota Board of Nursing