MINNESOTA
BOARD OF NURSING

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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

CERTIFIED MIDWIFE CONFIRMATION OF PROGRAM COMPLETION

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.

Until you are licensed, all data submitted on this form, 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 form become 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

Complete the applicant information below, and fax, email or mail the two-page *Certified Midwife Confirmation of Program Completion* form to the appropriate Certified Midwife program to complete the *Affidavit Section*.

The Certified Midwife program will return the completed two-page *Certified Midwife Confirmation of Program Completion* form to the Board by mail in an official school envelope or email to nursing.board@state.mn.us.

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
BIRTH DATE (mm/dd/yyyy)	GRADUATION DATE (mm/dd/yyyy)	
CERTIFIED MIDWIFE PROGRAM NAME (School name, no initials)		
CITY AND STATE OF CERTIFIED MIDWIFE PROGRAM		

☐ I authorize _____(name of Certified Midwife program) to release my educational dates to the Minnesota Board of Nursing.

_____ _____

Legal Signature Date (mm/dd/yyyy)

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AFFIDAVIT SECTION

↓ This Section for School Use Only - Applicant: Do Not Write Below This Line ↓

This two-page form must be mailed directly from the school in an official school envelope to the Minnesota Board of Nursing or emailed to nursing.board@stated.mn.us.

SCHOOL OFFICIAL: Complete the *Affidavit Section* after the applicant has fulfilled all requirements of the Certified Midwife program and has graduated from the program.

PROGRAM INFORMATION

Was the Certified Midwife program completed at a graduate level? YES ☐ NO ☐

Did the Certified Midwife program include clinical experience? YES ☐ NO ☐

Is the Certified Midwife program accredited by the American Commission for Midwifery Education or any successor organization recognized by the US Department of Education or the Council for Higher Education Accreditation? YES ☐ NO ☐

Completed graduate-level courses in each of the following areas:

Physiology and pathophysiology YES ☐ NO ☐

Advanced health assessment YES ☐ NO ☐

Advanced pharmacology, including pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents YES ☐ NO ☐

DEGREE TYPE ☐ Masters ☐ Other (explain) _____	GRADUATION DATE (mm/dd/yyyy)

The undersigned does hereby affirm that the information provided is true and correct.

_____

Legal Signature of School Official

_____ Affix School Seal or Stamp

Print Name and Title (Dean, Program Director or Institutional Registrar's Office)

SCHOOL OFFICIAL: Mail completed two-page form directly to Minnesota Board of Nursing in an official school envelope or email to nursing.board@state.mn.us directly from the school email address.