APPLICATION FOR TESTING AND SUBSEQUENT CERTIFICATION

AS A

CERTIFIED MIDWIFE (CM)

American Midwifery Certification Board ©
849 International Drive, Suite 120
Linthicum, MD 21090
410-694-9424 Phone
866-366-9632 Toll Free

The national certification examination is administered without regard to age, sex, race, religion, national origin, disability, or marital status of the candidate.

INSTRUCTIONS: Please type or print clearly. Do not use abbreviations. Each item must be complete for the application to be accepted. Incomplete or late applications will be returned unprocessed. Faxed applications will not be accepted.

Have you read and understood the AMCB *Candidates Handbook*? ☐ No ☐ Yes

If your answer is NO, or if no answer is given, AMCB will not process your application for certification.

PART I: General and Demographic

1. Name: _____
Last First Middle

2. Social Security Number: _____
Optional – For Internal Use Only

3. Address where test results and certificate are to be sent. ***Please notify AMCB if you relocate.*** *Information regarding Certificate Maintenance will be sent to the address below unless AMCB Headquarters is notified in writing of new address:*

_____
Street City State Zip Code

4. Name as it should appear on certificate: _____
Last Name above must be Identical

5. Home Phone Number: _____ 6. Cell Phone Number: _____

7. Email address: _____

8. Date of Birth: _____ 9. Gender (Optional): _____

10. Race (Optional, check one): *The information regarding ethnic identity is for statistical purposes only and will not be considered in reviewing your application.*

☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Asian Indian
☐ White
☐ Black or African American
☐ Other Race _____

11. Hispanic/Latino Ethnicity (Optional): ☐ No ☐ Yes 12. Primary Language: _____

13. I give my permission to be included in any periodic surveys related to certification or certification maintenance in which aggregate data without personal identifiers will be used: ☐ No ☐ Yes

14. I would be willing to be contacted by AMCB in the future regarding volunteer opportunities: ☐ No ☐ Yes

PART II: Background Check

15. Have you ever been subject to disciplinary action and/or has your professional license ever been limited, suspended or revoked by any of the following? ☐ No ☐ Yes

16. If YES to number 15 *(check all that apply)*:

☐ Federal Agency
☐ State Licensing Board
☐ Health Care Organization
☐ National Professional Association

17. Are you presently charged with or have you ever been convicted or found guilty of, or pleaded *nolo contendere* to any felony or misdemeanor directly relating to public health and safety and/or the provision of nurse-midwifery or midwifery services? ☐ No ☐ Yes

If your answer is YES to question 15 and/or 17 above, please explain on a separate sheet of paper.

18. Have you ever taken the national certification examination before? ☐ No ☐ Yes

If YES to number 18, attach documentation of the program most recently completed.

PART III: Education

19. Previous Midwifery Experience: ☐ No ☐ Yes

20. Name of Midwifery Program: _____

21. Type of program in which you were educated as a midwife:

☐ Precertification
☐ Certificate
☐ Baccalaureate
☐ Master's
☐ Certificate (also enrolled in Master's option)
☐ Post-Masters certificate
☐ Doctorate

22. Program Start Date _____ 23. Program Completion Date _____

24. What additional type of provider certification do you hold that enables you to provide woman's health care?

☐ Adult Health Nurse Practitioner (ANP)
☐ Family Nurse Practitioner (FNP)
☐ Women's Health Care Nurse Practitioner (WHCNP)
☐ None
☐ Other _____

25. Please identify all of your earned academic degrees. NOTE: This question does NOT refer to nursing diplomas or certificates received, such as FNP, or licensure as an RN, *(check all that apply)*:

☐ Associate, Nursing
☐ Associate, Not Nursing
☐ Bachelor's, Nursing
☐ Bachelor's, Not Nursing
☐ Master's, Nursing
☐ Master's, Midwifery
☐ Master's, Not Nursing
☐ Master's, Public Health
☐ Master's, Not Nursing, Midwifery, or Public Health
☐ Doctorate (any type e.g. DNP, PHD, etc.)
☐ Other _____

26. If you have identified that you hold a doctoral degree, please select the type of doctoral degree(s) you currently hold from the list below. If you select 'Doctorate, Other Type', please identify the type of doctoral degree you hold and the related discipline in which you hold this degree *(check all that apply)*:

☐ Doctorate of Nursing Practice (DNP) or Nursing Doctorate (ND)
☐ DNS or DNSc
☐ PhD (Nursing)
☐ Doctorate, Public Heath (Dr.PH) or DrPH (Public Health)
☐ PhD, other than Nursing _____
☐ Doctorate, other type (not PhD), e.g. JD, MD, PharmD _____
☐ Other _____

PART IV: Licensure

27. Please identify the number of states in which you hold an active license (or are otherwise authorized) to practice midwifery: _____

28. Please identify the name of the PRIMARY state or US territory where you are licensed to practice midwifery:

_____

29. Please provide the name of the PRIMARY state or US territory in which you work:

_____

30. Current registered nurse license (up to three):

States: _____ _____ _____

Numbers: _____ _____ _____

Expiration: _____ _____ _____

Attach a copy of a current nursing license or statement from the state detailing the information above (either must indicate licensure is active as of the date of application).

PART V: PROGRAM DIRECTOR CONFIRMATION REQUIRED

Be advised that no exam application will be processed without written confirmation on official school letterhead, signed by your program director, that you have successfully completed a graduate degree and Midwifery requirements, including the date it was completed and your date of birth. Please note that the program director must mail that confirmation to AMCB. Fax confirmations are NOT acceptable.

PART VI: Attestation

By signing below I verify that all information contained in this application is true and accurate. I authorize AMCB to request and receive information concerning matters relevant to this application and my certification. I authorize AMCB to communicate information concerning my application and certification status to public authorities, employers and others. I hereby represent that this application is submitted for the purpose of seeking AMCB certification and not for any other purpose. I understand that I am prohibited from, and agree that I will refrain from, copying, discussing, or otherwise disseminating to any other person or organization information about AMCB exam questions. I agree to abide by the terms of this application and the policies and procedures of the AMCB.

Applicant Signature: _____ Date Signed: _____

Please Print Name: _____

PART VII: Special Accommodations

Do you require **SPECIAL ACCOMMODATIONS** under the Americans with Disabilities Act?

□ No □ Yes

If YES, you must submit with the application relevant information about the disability; the specific accommodation(s) requested; proof of a history of accommodations(s), if any; and/or a written disability report prepared by an appropriately qualified, licensed health care professional.

PART VIII: Verification of Certification

You will receive one complimentary primary source verification letter upon successful completion of the examination. You may have this letter sent to another entity i.e. State Board of Nursing, OBGYN Practice, hospital, by providing the necessary information below.

Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

PART IX: Payment

Payments to the AMCB for examination fees are not deductible as charitable contributions for federal income tax purposes. They may be deductible under other provisions of the Internal Revenue Code. *Make a photocopy of this application for your records.*

Send the original application, a personal check, or credit card number and expiration date to:

American Midwifery Certification Board (AMCB)
849 International Drive, Suite 120
Linthicum, MD 21090

Payment by credit card (*AMCB accepts Visa, MasterCard, American Express and Discover.*):

Name on card: _____

Billing address for card: _____

_____

Card number: _____

Expiration date: _____ Security code: _____