STATE OF MARYLAND

MARYLAND BOARD OF NURSING
4140 PATTERSON AVENUE
BALTIMORE, MARYLAND 21215-2254

(410) 585-1900 (410) 358-3530 FAX
(410) 585-1978 AUTOMATED VERIFICATION
1-888-202-9861 TOLL FREE

CERTIFICATION TO PRACTICE AS A NURSE- MIDWIFE
CERTIFICATION INFORMATION SHEET

Applicants applying for certification to practice as a Nurse-Midwife in Maryland must submit the following:

1. A copy of your active Maryland Registered Nurse license or the Registered Nurse license from your state of legal residence.* A temporary RN license is not acceptable.

***Applicants living in Compact states that have implemented the RN licensure compact and that RN compact State is your state of legal residence:**

Submit proof of an active/current RN license issued by your legal state of residence.

2. A copy of the Nurse-Midwife certificate issued by the American Midwifery Certification Board (formerly known as the American College of Nurse-Midwives Certification Council, Inc.).

3. If applicable, a copy of the current CCA Cycle Card.**

****If your Nurse-Midwife certificate was issued without an expiration date, you must submit a copy of the current CCA (Continuing Competency Assessment) Cycle Card.**

4. $50.00 non-refundable application processing fee (check or money order) payable to the **Maryland Board of Nursing**.

5. Complete the application in its entirety.

6. Allow four (4) weeks for processing.

INCOMPLETE APPLICATIONS WILL REQUIRE ADDITIONAL PROCESSING TIME.

Once issued, the new Nurse-Midwife certification may be viewed and printed from the Board's website:
www.mbon.org --- "Look Up A Licensee"

APPLICATION-PROCESSING FEES

The non-refundable application-processing fee for the initial Maryland Advanced Practice Certification is $50.00.

The non-refundable application-processing fee for the second and third Advanced Practice Certification is $25.00 each.

STATE OF MARYLAND

MARYLAND BOARD OF NURSING
4140 PATTERSON AVENUE
BALTIMORE, MARYLAND 21215-2254

(410) 585-1900 (410) 358-3530 FAX
(410) 585-1978 AUTOMATED VERIFICATION
1-888-202-9861 TOLL FREE

APPLICATION FEE: $50.00 (NON REFUNDABLE)

MARYLAND BOARD OF NURSING
APPLICATION FOR CERTIFICATION TO PRACTICE
NURSE-MIDWIFERY

I hereby make application for certification to practice as a Nurse-Midwife in the State of Maryland in accordance with the Maryland Annotated Code, Health Occupations Article, Section 7-205 and the Regulations Governing the Practice of Nurse-Midwifery (10.27.05) and submit the following evidence of my qualifications for certification:

THIS DOCUMENT MUST BE TYPED
PLEASE DO NOT FAX OR EMAIL FORMS TO THE BOARD

NAME (as it appears on your license):		
(Last)	**(First)**	**(Middle/Maiden)**

ADDRESS:
(Number and Street)

(City)	**(State)**	**(Zip Code)**

UNLESS THE ADVANCED PRACTICE DEPARTMENT RECEIVES WRITTEN NOTIFICATION OF A CHANGE OF ADDRESS, ALL CORRESPONDENCE ASSOCIATED WITH THIS APPLICATION WILL BE MAILED TO THE ABOVE ADDRESS.

DATE OF BIRTH:	***Attach a copy of your RN license.***
MARYLAND RN LICENSE #:**	****Applicants living in Compact states that have implemented the RN Licensure Compact, please list and attach a copy of the RN license issued by your state of legal residence.***
SOCIAL SECURITY #:	
WORK TELEPHONE #:	**HOME TELEPHONE #:**
E-MAIL ADDRESS:	

THIS DOCUMENT MUST BE TYPED

CERTIFICATION BY THE AMERICAN MIDWIFERY CERTIFICATION BOARD (AMCB)
(FORMERLY KNOWN AS: ACNM CERTIFICATION COUNCIL, INC.).

DATE OF ORIGINAL CERTIFICATION:	***Submit a copy of your certificate with this application.***
EXPIRATION DATE OF CURRENT CERTIFICATE:	****If your Nurse-Midwife certificate was issued without an expiration date, you must submit a copy of the current CCA (Continuing Competency Assessment) Cycle Card.***
EXPIRATION OF CURRENT CCA CYCLE (IF APPLICABLE):	

TYPE THE NAME YOU WOULD LIKE TO APPEAR ON YOUR CERTIFICATE:

THE CERTIFIED NURSE-MIDWIFE WILL PRACTICE WITH A WRITTEN PLAN FOR CONSULTATION, COLLABORATION AND REFERRAL. (AUTHORITY: COMAR 10.27.05.)

I _____ hereby declare and affirm that all information
(type name)
contained in this form is true and complete to the best of my knowledge, information, and belief. I understand that I must submit a collaborative plan in accordance with the Maryland Board of Nursing's requirements before I begin my practice in Maryland as a Certified Nurse Midwife. **(Providing false or misleading information may result in disciplinary action by the Board.)**

ORIGINAL SIGNATURE: _____ DATE SIGNED: _____

MAIL TO:
ADVANCE PRACTICE DEPARTMENT
MARYLAND BOARD OF NURSING
4140 PATTERSON AVENUE
BALTIMORE, MD 21215-2254
(410) 585-1926

Revised: November 2010

STATE OF MARYLAND

MARYLAND BOARD OF NURSING
4140 PATTERSON AVENUE
BALTIMORE, MARYLAND 21215-2254

(410) 585-1900 (410) 358-3530 FAX
(410) 585-1978 AUTOMATED VERIFICATION
1-888-202-9861 TOLL FREE

THIS DOCUMENT MUST BE TYPED

DECLARATION OF RESIDENCE FOR ADVANCE PRACTICE

PLEASE RETURN COMPLETED FORM WITH YOUR ORIGINAL SIGNATURE TO THE MARYLAND BOARD OF NURSING

NAME: _____

ADDRESS: _____
(CURRENT MAILING ADDRESS)

CITY: _____

STATE: _____ **Zip Code** _____

NURSING LICENSE NUMBER _____ **ISSUING STATE** _____

I DECLARE THAT _____ **IS MY LEGAL STATE OF RESIDENCE.**

_____
ORIGINAL SIGNATURE AND DATE

ENCLOSE COPIES OF TWO OF THE FOLLOWING OFFICIAL PROOFS OF RESIDENCY

- Current driver's license – must include a home street address
- Voter's registration card
- Federal income tax return
- W2 from any US government, bureau division or agency
- Military Form #2058-state of legal residence certificate