Application for Midwifery License by Examination

Department of Health/Council of Licensed Midwifery
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: FloridaHealth.gov/licensing-and-regulation/midwifery/
Email: MQA.Midwifery@FLHealth.gov
Phone: (850) 245-4161
Fax: (850) 412-2681

DH-MQA 1051, Revised 5/2025, Rule 64B24-2.001, F.A.C.

Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at http://www.flhealthsource.gov/valor.

DH-MQA 1051, Revised 5/2025, Rule 64B24-2.001, F.A.C.

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P.O. Box 6330
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Do Not Write in this Space
For Revenue Receipting Only

More information about the licensing process and requirements is available at www.floridahealth.gov/licensing-and-regulation/midwifery/.

Certified Nurse Midwives (CNM) should not apply with the Council of Licensed Midwifery. CNMs must apply with the Board of Nursing at https://floridasnursing.gov/.

Midwife (3201) by **Examination** (1010) **$705.00**

Total fee of $705.00 includes the following:

Application Fee (non-refundable)	$200.00
Initial Licensure Fee (refundable)	$500.00
Unlicensed Activity Fee (refundable)	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street (Place of Employment) Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the council office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Social Security Disclosure Information: * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

You may apply for licensure before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Include **all** names which may appear on documents submitted in support of your application. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice midwifery or any other health-related license(s)?
☐ Yes ☐ No

C. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

For any license(s) listed, you may be required to submit official license verification.
Council staff will attempt to verify all licenses listed using available primary-source verification tools (i.e. online verification portals). If primary-source verification is not available, you will be notified in writing that official license verification is required. A copy of your license will not be accepted in lieu of official verification.

4. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

5. EDUCATION AND TRAINING HISTORY

A. **Midwifery Education and Training:** List the midwifery or other training program you attended.

Program Name	Program State or Country	Graduation Date (MM/DD/YYYY)

☐ **Applicants who completed their midwifery education and training in Florida must have an official transcript sent directly to the council office from their Florida council approved midwifery program. Unofficial transcripts and copies submitted by applicants are not acceptable.**

If you attended a Florida council approved midwifery program:
☐ I authorize the Florida council approved midwifery program listed above to release my transcript.

☐ **Applicants educated in another state must have their education and training evaluated by a Florida council approved midwifery program.**

☐ **Applicants educated in another country must have their education and training evaluated by an education credentialing service.**

Uncredentialed education documents and copies of education credentialing documents submitted by applicants will not be accepted.

Credentialing must be completed on Form DH-MQA 5071, "Licensed Midwife Education and Training Evaluation," available online at https://www.floridahealth.gov/licensing-and-regulation/midwifery/resources.

B. **Prelicensure Course:** Applicants educated in another state or country must complete a prelicensure course with a Florida council approved midwifery program.

If you completed your midwifery education in another state or country, list the Florida council approved midwifery program where you completed your prelicensure course.

Approved Midwifery Program Name	Completion Date (MM/DD/YYYY)
☐ I authorize the approved midwifery program listed above to release my prelicensure transcript.	

6. EXAMINATION HISTORY

North American Registry of Midwives (NARM) - Examination Results:

☐ I have not yet taken the required NARM examination.

☐ I have taken the required NARM examination.

☐ **All applicants must request that their NARM results be sent directly to the council office. NARM results submitted by applicants will not be accepted.**

For additional information about the NARM examination, visit narm.org.

Requests for agency authorization to test made directly by applicants will not be accepted.
If you require authorization to test, contact the Florida council approved midwifery program where you completed your prelicensure course.

7. GENERAL EMERGENCY CARE PLAN

☐ **All applicants are required to provide a general emergency care plan pursuant to s. 467.017(1), Florida Statutes.**

Submit your general emergency care plan on Form DH-MQA 1077, "General Emergency Care Plan for Licensed Midwives." The form is available online at http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources. **The form required in this section may be submitted with your application.**

After submission of this application, the required form may be submitted by:

- uploading the form using the MQA Online Services Portal (www.flhealthsource.gov),
- emailing the form to MQA.Midwifery@flhealth.gov, or
- mailing the form to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

This information is exempt from public records disclosure.

8. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the council office:

☐ **A written self-explanation** which identifies the medical condition(s) or occurrence(s) and current status.

☐ **A letter from a Licensed Health Care Practitioner** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on your ability to practice the profession with reasonable skill and safety. The letter must specify that you are safe to practice the profession without restrictions, or indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- uploading the documents using the MQA Online Services Portal (www.flhealthsource.gov),
- mailing the documents to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

9. DISCIPLINE HISTORY

A. Have you ever had any professional license or license to practice revoked, suspended, placed on probation, or received a disciplinary action taken in any state, territory, or jurisdiction? ☐ Yes ☐ No

B. Have you ever had any application for a license to practice a profession, including midwifery, denied by any state board/council or the licensing authority of any state, territory, or jurisdiction? ☐ Yes ☐ No

C. Are you currently under investigation or is any disciplinary action pending against you in any state, territory, or jurisdiction that would constitute a violation of s. 467.203, Florida Statutes? ☐ Yes ☐ No

D. Have you ever been notified to appear before any licensing agency for a hearing on a compliant of any nature, including, but not limited to, a charge of violation of the midwifery and/or medical practice act(s), for unprofessional or unethical conduct? ☐ Yes ☐ No

If you responded "Yes" to any of the questions above, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to question A, B, C, or D, you must provide the following:

☐ **A written self-explanation**, which describes in detail the circumstances surrounding each disciplinary action, denial, investigation, or hearing.

☐ A copy of the **Administrative Complaint** and **Notice of Intent to Deny or Final Order**.

☐ **Any other relevant filings** entered by the licensing agency related to the action taken.

E. Have you ever had any judgements entered against you related to the practice of midwifery or any other health care profession? ☐ Yes ☐ No

F. Have you ever been sued for malpractice? ☐ Yes ☐ No

If you responded "Yes" to question E or F, you must provide the following:

☐ **A written self-explanation** which describes in detail your involvement in each case.

☐ A copy of the **Complaint** and **Disposition** for each case.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- uploading the documents using the MQA Online Services Portal (www.flhealthsource.gov),
- emailing the documents to MQA.Midwifery@flhealth.gov, or
- mailing the documents to:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3255

10. CRIMINAL HISTORY

*For the questions below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.*

*Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.*

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? ☐ Yes ☐ No

B. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? ☐ Yes ☐ No

If you responded "Yes" to any question in this section, complete the following:

Offense	Jurisdiction/State	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any question in this section, you must provide the following:

☐ **A written self-explanation** which describes in detail the circumstances surrounding each offense and includes the date of the offense, where the offense occurred (city and state), the charge(s), and the final disposition(s).

☐ **Arrest Records and Final Dispositions** for all offenses. The Clerk of Court in the jurisdiction where the offense took place will provide you with these documents. *If records are unavailable*, documentation of the unavailability of records must come from the Clerk of Court in the jurisdiction where the offense took place, in the form of a letter which states that the records are unavailable.

☐ **Completion of Sentencing Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the sentence was completed.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- emailing the documents to MQA.BackgroundScreen@flhealth.gov, or
- mailing the documents to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

Name: _____

11. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida Statutes? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

   b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** for each "Yes" response which describes in detail the circumstances surrounding the termination or conviction and includes the county and state of each termination or conviction and the date of each termination or conviction.

☐ **Copies of supporting documentation** includes court dispositions or agency orders, if applicable.

Documents required in this section may be submitted with this application.

After submission of this application, required documents may be submitted by:

- emailing the documents to MQA.BackgroundScreen@flhealth.gov, or
- mailing the documents to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

12. LIVESCAN PRIVACY STATEMENT

☐ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation (found in the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

☐ **Electronic Fingerprinting:** **(Required for ALL applicants)**

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: http://www.flhealthsource.gov/background-screening/.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The council's ORI number is **EDOH4620Z**. The council cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided instructions on how to retain their fingerprints to avoid having to submit a new background screening.

Name: _____

13. FINANCIAL RESPONSIBILITY

Midwives are required to carry professional liability insurance coverage in an amount not less than $100,000.00 per claim with a minimum annual aggregate of not less than $300,000.00 through an authorized insurer as defined under s. 624.09, Florida Statutes, a surplus lines insurer as defined under s. 626.914., Florida Statutes, a risk retention group as defined under s. 627.942, Florida Statutes, the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or a plan of self-insurance as provided in s. 627.357, Florida Statutes, unless exempt from financial responsibility coverage for one of the reasons below.

Council staff cannot advise as to your financial responsibility or malpractice insurance coverage. If you have questions regarding your financial responsibility, insurance coverage, or requirements for exemption, consult your legal counsel, insurance company, or financial institution.

Choose only one option that describes your professional liability insurance coverage status or exemption from financial responsibility.

☐ **I have obtained and will maintain professional liability insurance coverage** in an amount not less than $100,000.00 per claim with a minimum annual aggregate of not less than $300,000.00 from a provider as described herein.

☐ **I am exempt from financial responsibility coverage** because I practice exclusively as an officer, employee, or agent of the federal government, or of the state of Florida or its agencies or subdivisions.

☐ **I am exempt from financial responsibility coverage** because I will be practicing exclusively in conjunction with my teaching duties with an approved midwifery program.

☐ **I am exempt from financial responsibility coverage** because I will not be practicing in the state of Florida upon issuance of my midwifery license and will submit proof of professional liability coverage at least 15 days prior to beginning practice in the state of Florida.

☐ **I am exempt from financial responsibility coverage** because I have no malpractice exposure in the state of Florida.

14. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

Florida law requires me to immediately inform the council of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the Department of Health.

Applicant Signature _____ Date _____

You may print this application and sign it or sign digitally. MM/DD/YYYY

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record to be employed, licensed, work under contract, or serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Person with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same or similar to yours.
Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of your record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, Florida Statutes, and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.
Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub. L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosure to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional information: The requesting agency and/or the agency conducting the application investigation will provide additional information to the specific circumstances of this application, which may include identification of other authorities, purposes, uses and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Council of Licensed Midwifery
Electronic Fingerprinting

Take this form with you to the Livescan service provider. Check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: http://www.flhealthsource.gov/background-screening/.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the board office will not receive your background screening results.
- The ORI number for the Council of Licensed Midwifery is **EDOH4620Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- Typically background screening results submitted through a Livescan service provider are received by the board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ SSN#: _____
Last First Middle

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: -_____ Sex: -_____
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.