



Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing  
Board of Certified Direct-Entry Midwives  
P.O. Box 110806  
Juneau, Alaska 99811-0806  
Phone: (907) 465-2580 Fax: (907) 465-2974  
E-mail: [license@alaska.gov](mailto:license@alaska.gov)  
Website: [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ)

## PROCEDURES FOR OBTAINING CERTIFICATION BY EXAMINATION AS A DIRECT-ENTRY MIDWIFE

The following items must be on file before your application will be considered by the board:

- 1. Complete, notarized application form, including photograph. (form 08-4215)
- 2. Nonrefundable application fee - \$250.00.
- 3. Copy of current certification in:
  - (A) Basic Life Support for Health Care Providers (BLS).
  - (B) Neonatal Resuscitation;
  - (C) intravenous therapy treatment for Group B *Streptococci*, from the Midwives' Association of Alaska (MAA), or from a program approved by the Midwifery Education Accreditation Council (MEAC); and
  - (D) intravenous therapy from the Midwives' Association of Alaska (MAA), or from a program approved by the Midwifery Education Accreditation Council (MEAC).
- 4. Authorization for Release of Records (form 08-4215a).
- 5. Attests to 12 AS 08.65.050(3) for Professional Fitness.
- 6. Proof of passing the examination prepared and graded by the North American Registry of Midwives (NARM). These results must be mailed directly to the board from NARM.
- 7. Course of Study: To document completion of the required Course of Study, one of the following must be submitted:
  - An official transcript, diploma, or certificate of graduation from a MEAC accredited institution. This document must be an official copy mailed directly to the board from the institution where you completed your study.
  - OR
  - Course of Study Certification form (form 08-4215d). This form must be signed by your Primary Preceptor and notarized.
- 8. Pharmacology Protocols (Documentation of Pharmaceutical Knowledge as pertains to Midwifery Practice (form 08-4215e).
- 9. Verification of Supervised Clinical Experience, Parts I, II and III (form 08-4215c).
- 10. Verification of Licensure (form 08-4215g). The Verification of Licensure form must be completed by and mailed directly to the board from all states in which you hold or have held a permit or license to practice midwifery.
- 11. Certification of Completion of the Practical Skills List for Alaska CDM's. (Form 08-4215h)
- 12. Certification fee of \$1250.00. The certification fee can be submitted after board approval; however, certification cannot be issued until the fee has been received. Payment by credit card may be made by using the Credit Card Authorization Form at: [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ)
- 13. Documentation of Competence in Permitted Practices (form 08-4215f).

**A wall certificate suitable for framing can be obtained by submitting a written request along with the \$20.00 fee pursuant to 12 AAC 02.105(8).**

## EXAMINATION INFORMATION

**Applications to take the Northern American Registry of Midwives Examination (NARM) must be received in the division Juneau office at least 60 days before the date of the examination for which you are applying.** The NARM examination is generally offered on the third Wednesday in February and August of each year in Anchorage, Fairbanks and Juneau. Contact the division for specific examination and application deadline dates. To be considered for examination, the following documents must be received by the deadline date:

1. Items 1-3(A & B), 4 and 5 listed on the front cover sheet.
2. Academic Program Completion form completed by preceptor (form 08-4215b).

The examination fee of \$700.00 must be paid directly to NARM. Instructions for registering with NARM will be sent to applicants upon board approval of examination application.

Upon successful passage of the examination, all other requirements listed on the cover sheet must be submitted and approved by the board before certification will be issued. In order to be scheduled for review by the board at its next regularly scheduled meeting, the additional documentation required for certification/licensure, items 3 C and D, and Items 7 through 14 (and Item 6 if you have already passed the NARM examination) must be received by the division's Juneau office at least 30 days before the date of the next regularly scheduled meeting of the board. The board generally meets on the last Thursday/Friday of February and August. Contact the division for specific dates and deadlines.

An applicant who has failed the examination may not retake the examination for a period of six months. In addition, an applicant who has failed the examination more than one time may not retake the examination unless the applicant has participated in or successfully completed further education and training programs as prescribed by the board.

## CREDENTIAL INFORMATION

The board will, in its discretion, issue a certificate without examination to an applicant who meets the requirements of AS 08.65.070 and 12 AAC 14.120. An applicant shall also provide documentation of fulfillment of the continuing competency requirements in 12 AAC 14.420 - 12 AAC 14.430 during the two years immediately preceding the date of application for certification. **If you are licensed in another jurisdiction and would like to apply for certification by credentials, you must use a different application entitled "Procedures for Obtaining Certification by Credentials as a Direct-Entry Midwife."**

## SPECIAL ACCOMMODATION(S) FOR EXAMINATION

Programs under the jurisdiction of the Division of Corporation, Business and Professional Licensing are administered in accordance with the Americans with Disabilities Act (ADA). If you require special accommodation when taking the licensing examination, you must submit a completed "Application for Examination Accommodation for Candidates with Disabilities" form by the application deadline date. This form is available on the division's website: [www.commerce.state.ak.us/occ/](http://www.commerce.state.ak.us/occ/) or contact the division to request the form.

## SOCIAL SECURITY NUMBER

The department is not authorized to issue a license unless the applicant's Social Security Number is provided. If you do not have a United States Social Security Number, please complete the "Request for Exception from Social Security Number Requirement" form located on the divisions' website at [www.commerce.state.ak.us/occ/](http://www.commerce.state.ak.us/occ/) or contact the division for the form.

## PAYMENT OF CHILD SUPPORT AND STUDENT LOANS

If the Alaska Commission on Postsecondary Education has determined you are in loan default or if the Alaska Child Support Enforcement Division has determined you are in arrears on child support, you will be issued a nonrenewable temporary license valid for 150 days. Contact Postsecondary Education at 1-800-441-2962 or (907) 465-2962 or Child Support Services at (907) 269-6657 if your last name begins with A – M; Contact (907) 269-6845 if your last name begins with N – Z; or 1-800-478-3300 to resolve payment issues.

## GENERAL INFORMATION

All certificates expire December 31 of even-numbered years regardless of when issued, except new certificates issued within 90 days of the expiration date will be issued through the next biennial license period.



**PROFESSIONAL FITNESS** (Alaska Statute 08.65.050(3), AS 08.65.110 and 12 AAC 14.140)

If any of the following questions are answered "yes," full details must be furnished on a separate piece of paper and attached to this application.

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Have you ever been disciplined by any state board or Midwife Association concerning violation of the Midwifery Practice Act or unethical conduct? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been called before any state board or department for interrogation concerning any violation of the laws or rules pertaining to the profession for which you are applying or unethical conduct? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been denied a certificate or license by, or the privilege of taking an examination before any state Board? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been convicted of any criminal offense other than a minor traffic violation? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been convicted of a violation of any federal or state narcotic laws? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a license to practice midwifery revoked, suspended, restricted, limited or surrendered (voluntary or involuntary)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Within the past five years, have you been addicted to, or excessively used or misused alcohol, narcotics, barbiturates or habit-forming drugs? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Within the past five years, have you been or are you currently being treated for bipolar disorder, schizophrenia, paranoia, psychotic disorder, substance abuse, depression (except for situational or reactive depression) or any other mental or emotional illness? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have any disability or illness which could affect your ability to safely practice midwifery? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. List below any malpractice actions that have been filed against you, including the nature of the case, date, and address of court where it is filed, and case status.  |                          |                          |

\_\_\_\_\_  
\_\_\_\_\_

I certify I have reviewed AS 08.65.050(3) and AS 08.65.110 and attest that I have not engaged in conduct that is a ground for imposing disciplinary sanctions as referenced under AS 08.65.110 .

OR

I certify I have also reviewed AS 08.65.050(3) and AS 08.65.110 and attest I DO NOT MEET AS 08.65.110 and I have included the applicable documentation.

AND

I certify per 12 AAC 14.140 the information provided on this application and all forms accompanying it are true and correct.

If you answered "Yes" to any questions or statements, please submit a signed and dated detailed statement of explanation and a copy of the legal documentation, if applicable. All information supplied with the application is considered public information, except information considered to be private by state or federal law. Licensee information, including mailing addresses, is available on the division's website at [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ) under "License Search."

\_\_\_\_\_  
Signature of Applicant

SUBSCRIBED AND SWORN TO BEFORE ME THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_\_.

**ATTACH RECENT PHOTOGRAPH HERE**

Passport size taken within one year of application

**SEAL**  
Notary seal must cover portion of photograph.

\_\_\_\_\_  
Notary Public

Notary Public for \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

**WARNING:**  
Alaska Statute 11.56.210 states that any person who knowingly, or intentionally, furnishes false or fraudulent information in an application has committed a class A misdemeanor. Any false or misleading information may result in failure to obtain registration or subsequent revocation of registration.

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## AUTHORIZATION FOR RELEASE OF RECORDS

### TO WHOM IT MAY CONCERN:

I, \_\_\_\_\_, residing at \_\_\_\_\_

\_\_\_\_\_, authorize the Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine my medical, employment, education records, and records pertaining to litigation, judgments, suits and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of all such records pertaining to me to the Alaska Division of Corporations, Business and Professional Licensing and its investigators.

I authorize the division to discuss my records with persons or organizations which are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the division.

This release also applies to any documents or records which contain information pertaining to psychiatric, drug or alcohol evaluation, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis, or treatment.

I request that upon presentation of this release, or a Certified True Copy, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization is given expressly in connection with my application for a permit to practice as a direct-entry midwife.

Home Telephone: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**ACADEMIC PROGRAM COMPLETION CERTIFICATION**  
(Required for examination application)  
12 AAC 14.200(c)(2)

The following section needs to be completed by the applicant's course of study provider.

I, \_\_\_\_\_, certify that  
*(Name of Course of Study Provider)*

\_\_\_\_\_ has completed the academic portion  
*(Student Name)*

of her/his apprenticeship under my direction on this date \_\_\_\_\_. The academic  
*(Date of Completion)*

program meets the course of study requirements of 12 AAC 14.200.

\_\_\_\_\_  
Signature of Course of Study Provider

\_\_\_\_\_  
Name of Course of Study

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

SEAL

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

# INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

**PART I form 08-4215c** (to be completed by the applicant)

- a. **Observes**
- b. **Assists**
- c. **Primary**

All births are to be listed in chronological order and numbered.

**Part I a.** – List 10 birth **observations** as required by 12 AAC 14.210(b)(2)

**Part I b.** – List 20 birth **assists** with labor management as required by 12 AAC 14.210(b)(3)

**Part I c.** – List 30 **primary births** with responsibility for labor and delivery as required by 12 AAC 14.210(b)(4)

**CONTINUOUS CARE CLIENTS.** As part of the supervised clinical experiences required, an applicant must have provided continuous care to at least 15 clients. "Continuous Care" means, for the same client, the applicant

1. performed at least six prenatal visits;
2. observed, assisted with, or had primary responsibility for labor and delivery of the newborn and placenta;
3. performed a newborn examination; and
4. performed a postpartum examination of the mother.

**Subtotals and the date you met the requirement must be indicated at the bottom of each page.** You must list any and all births that you were involved with.

You must document, on a separate sheet of paper, any complications and their outcomes for **ALL** births listed. Note the birth number and type from form 08-4215c.

**PART II** (to be completed by the applicant)

In "A," you must list your primary preceptor and all secondary preceptors who supervised you during your apprenticeship. You must also write in the total number of each activity under each preceptor. Make additional copies of the page as needed.

In "B," you must give the totals of your experiences for the complete apprenticeship. Enter **ONLY** one final total, regardless of how many preceptors you worked under.

**PART III** (to be completed by preceptor(s))

Each preceptor that supervised you must complete a Part III form. The numbers given on the Part III form must match the numbers given on Part II A for each preceptor.

**NOTE: Apprentice is required to comply with 12 AAC 14.130(e) an apprentice direct-entry midwife shall submit written notice to the department within 30 days after any addition or change to the relationship with the apprenticeship program preceptor.**

**ALL SECTIONS ON ALL FORMS MUST BE FILLED IN. MISSING INFORMATION WILL CAUSE DELAYS IN THE PROCESSING OF YOUR APPLICATION.**



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**PART I b. – ASSISTS - VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE**

Location of Birth Assists Attended (City & State) <i>(Do Not Write in Patient Names)</i>			Date of Birth, Weight and Sex in Chronological Order	S – Supervising Licensee (MD-CNM-CDM) P – Primarily Responsible for Labor & Delivery A – Assisted with Labor Management	No. of Prenatal Visits Conducted by Applicant	Newborn Exam Yes/No	No. of Postpartum Examinations of Mother Conducted by Applicant
	Number	DOB _____	S: _____		YES <input type="checkbox"/>		
		Weight _____	P: _____		NO <input type="checkbox"/>		
Continuous Care Client	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sex _____	A: _____				
<b>Totals This Page</b>	<b>Assists with Labor Management</b>			<b>PART I b. – ASSISTS CONTINUED ON NEXT PAGE</b>			
	<b>Prenatal Visits</b>						
	<b>Newborn Exams</b>						
	<b>Postpartum Exams</b>						
	<b>Continuous Care Clients</b>						



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**PART I c. – PRIMARY - VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE**

Location of Primary Births Attended (City & State) <i>(Do Not Write in Patient Names)</i>			Date of Birth, Weight and Sex in Chronological Order	S – Supervising Licensee (MD-CNM-CDM) P – Primarily Responsible for Labor & Delivery A – Assisted with Labor Management	No. of Prenatal Visits Conducted by Applicant	Newborn Exam Yes/No	No. of Postpartum Examinations of Mother Conducted by Applicant
	Number	DOB _____	S: _____			YES <input type="checkbox"/>	
		Weight _____	P: _____			NO <input type="checkbox"/>	
Continuous Care Client	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sex _____	A: _____				
<b>Totals This Page</b>	<b>Primaries</b>		<b>Prenatal Visits</b>				
	<b>Continuous Care Clients</b>		<b>Newborn Exams</b>				
			<b>Postpartum Exams</b>				

PART I c. – PRIMARY  
 CONTINUED ON NEXT PAGE

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**PART I c. – PRIMARY - VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE**

Location of Primary Births Attended (City & State) <i>(Do Not Write in Patient Names)</i>			Date of Birth, Weight and Sex in Chronological Order	S – Supervising Licensee (MD-CNM-CDM) P – Primarily Responsible for Labor & Delivery A – Assisted with Labor Management	No. of Prenatal Visits Conducted by Applicant	Newborn Exam Yes/No	No. of Postpartum Examinations of Mother Conducted by Applicant
	Number		DOB _____	S: _____		YES <input type="checkbox"/>	
	Yes No		Weight _____	P: _____		NO <input type="checkbox"/>	
Continuous Care Client	<input type="checkbox"/> <input type="checkbox"/>		Sex _____	A: _____		<input type="checkbox"/>	
<b>Totals</b>	<b>Primaries</b>			<b>Prenatal Visits</b>			
<b>This</b>	<b>Continuous Care Clients</b>			<b>Newborn Exams</b>			
<b>Page</b>				<b>Postpartum Exams</b>			

PART I c. – PRIMARY  
 CONTINUED ON NEXT PAGE



## PART II – VERIFICATION OF CLINICAL EXPERIENCE

**A. Sub-Totals** must be indicated for each supervising preceptor. You must list all preceptors, make additional copies of this page as needed.

T O T A L S	Primary Preceptor Name:		Midwife License #:	
	Primary Labor & Deliveries		Prenatal Visits	
	Assisted Labor Managements		Newborn Exams	
	Observations		Postpartum Exams	

T O T A L S	Primary Preceptor Name:		Midwife License #:	
	Primary Labor & Deliveries		Prenatal Visits	
	Assisted Labor Managements		Newborn Exams	
	Observations		Postpartum Exams	

T O T A L S	Primary Preceptor Name:		Midwife License #:	
	Primary Labor & Deliveries		Prenatal Visits	
	Assisted Labor Managements		Newborn Exams	
	Observations		Postpartum Exams	

T O T A L S	Primary Preceptor Name:		Midwife License #:	
	Primary Labor & Deliveries		Prenatal Visits	
	Assisted Labor Managements		Newborn Exams	
	Observations		Postpartum Exams	

**B. Final Totals - All Activities**

Primary Labor & Deliveries		Newborn Examinations	
Assisted Labor Managements		Postpartum Examinations	
Observations			
Continuous Care Clients			
Prenatal Visits			

I declare the above information is true and correct to the best of my knowledge. I also understand that if I falsify any information, I may forfeit the opportunity to be certified in the State of Alaska.

Applicant's Signature \_\_\_\_\_ Date: \_\_\_\_\_

### PART III – VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Applicants must verify clinical experience under the supervision of a preceptor who meets the qualifications of 12 AAC 14.210.

I, \_\_\_\_\_, certify that \_\_\_\_\_  
*(Name of Preceptor)* *(Name of Applicant)*

obtained clinical experience under my supervision, which included the following number of experiences (as documented on **Part I a,b,c** of form 08-4215c):

- \_\_\_\_\_ Number of prenatal visits (100 required for certification).
- \_\_\_\_\_ Number of labor and delivery observations (10 required for certification).
- \_\_\_\_\_ Number of assisted labor managements (20 required for certification).
- \_\_\_\_\_ Number of labors and deliveries of the newborn and placenta in which the applicant was the primary responsible person (30 required for certification).
- \_\_\_\_\_ Number of newborn examinations (30 required for certification).
- \_\_\_\_\_ Number of postpartum examinations of the mother (30 required for certification).

Documentation of clinical experience on Part I must include:

1. Date of birth.
2. Location of birth.
3. Infant's gender.
4. Infant's weight.
5. Name of person who assisted at the birth (A = Assistant).
6. Name of person who delivered the newborn and placenta (P = Primary Midwife).
7. Number of prenatal and postpartum visits applicant participated in on each client.
8. A detailed explanation of any complication and its outcome. (Please attach separate piece of paper.)
9. A detailed explanation of any situation that required emergency transport. (Please attach separate piece of paper.)

**To be completed by person verifying experience.**

I certify that all information provided on this form is true and correct and that the care provided was within the scope of AS 08.65 and 12 AAC Chapter 14.

NOTARY SEAL

\_\_\_\_\_  
Signature of Preceptor Date

\_\_\_\_\_  
Type of License

\_\_\_\_\_  
CDM License No. State of Licensure

\_\_\_\_\_  
Original Issue Date Expiration Date

SUBSCRIBED AND SWORN TO before me, a notary public, in and for the state of \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_

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**COURSE OF STUDY CERTIFICATION**

\_\_\_\_\_  
(Name of Applicant)

Pursuant to 12 AAC 14.200(c), an applicant shall document completion of a course of study that meets the requirements of 12 AAC 14.200(a).

Pursuant to 12 AAC 14.200(d), the board may require documentation necessary to verify study of a subject, including an essay written by the applicant on subjects studied independently.

As the applicant, I certify that I have completed a course of study that meets the requirements of 12 AAC 14.200(a).

\_\_\_\_\_  
**Printed Name of Applicant**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

As the course of study provider, I certify that the applicant has successfully completed the course of study required per 12 AAC 14.200(a).

\_\_\_\_\_  
**Printed Name of Course of Study Provider**

\_\_\_\_\_  
Signature of Course of Study Provider

\_\_\_\_\_  
Date

SUBSCRIBED AND SWORN TO before me, a notary public in and for the State of \_\_\_\_\_,

this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

NOTARY SEAL

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

As the preceptor, I certify that the applicant has successfully completed the required course of study and certification is true and correct to the best of my knowledge.

\_\_\_\_\_  
**Printed Name of Primary Preceptor**

\_\_\_\_\_  
Signature of Primary Preceptor

\_\_\_\_\_  
Date

SUBSCRIBED AND SWORN TO before me, a notary public in and for the State of \_\_\_\_\_,

this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

NOTARY SEAL

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

**ONLY COURSE OF STUDY PROVIDER AND PRECEPTOR NEED TO NOTARIZE THEIR SIGNATURE**

<b>12 AAC 14.570 MEDICATIONS</b>	Complete the following regarding the below medications as it pertains to the practice of midwifery in Alaska.
<b>Xylocaine hydrochloride/ Cetacaine</b>	Indication: Dose (range): Method of Administration: Side effects: Contraindications: Pharmacology/Actions:
<b>Vitamin K</b>	Indication: Dose (range): Method of Administration: Side effects: Contraindications: Pharmacology/Actions:
<b>Rhogam</b>	Indication: Dose (range): Method of Administration: Side effects: Contraindications: Pharmacology/Actions:
<b>Eye Prophylaxis (Neonatal )</b>	Indication: Dose (range): Method of Administration: Side effects: Contraindications: Pharmacology/Actions:
<b>Pitocin</b>	Indication: Dose (range): Method of Administration: Side effects: Contraindications: Pharmacology/Actions:
<b>Methergine</b>	Indication: Dose (range): Method of Administration: Side effects: Contraindications: Pharmacology/Actions:

Receipt of your GBS/IV Therapy Certificate documents knowledge of and training of the following medications:

1. Lactated ringers, D5LR, NS
2. Antibiotic (CDC) guidelines
3. Epinephrine
4. Diphenhydramine

NAME \_\_\_\_\_

**12 AAC 14.560 - Permitted Practices**

**Document your competence in the following permitted practices by providing the resources of your training and skills. Each permitted practice must then be signed off by your preceptor.**

Catherization of the Urinary Bladder	Resources
I certify that applicant has acquired the training and skills necessary to safely perform catherization of the urinary bladder.	
Preceptor Signature: _____	

Clamping & Cutting of the Umbilical Cord	Resources
I certify that applicant has acquired the training and skills necessary to safely perform clamping and cutting of the umbilical cord.	
Preceptor Signature: _____	

Artificial Rupture of the Amniotic Membranes	Resources
I certify that applicant has acquired the training and skills necessary to safely perform the artificial rupturing of amniotic membranes.	
Preceptor Signature: _____	

Venipuncture	Resources
I certify that applicant has acquired the training and skills necessary to safely perform venipuncture.	
Preceptor Signature: _____	

\_\_\_\_\_  
Applicant Name

**12 AAC 14.560 - Permitted Practices**

**Document your competence in the following permitted practices by providing the resources of your training and skills. Each permitted practice must then be signed off by your preceptor.**

Capillary blood sampling	Resources
I certify that applicant has acquired the training and skills necessary to safely perform capillary blood sampling.	
Preceptor Signature: _____	

Suturing	Resources
I certify that applicant has acquired the training and skills necessary to safely perform suturing.	
Preceptor Signature: _____	

Intramuscular Injection	Resources
I certify that applicant has acquired the training and skills necessary to safely perform intramuscular injections.	
Preceptor Signature: _____	

Episiotomy	Resources
I certify that applicant has acquired the training and skills necessary to safely perform an episiotomy.	
Preceptor Signature: _____	

\_\_\_\_\_  
Applicant Name



Has the applicant's license ever been suspended or revoked?  No  Yes

If yes, for what reason? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the applicant been subject to any other disciplinary action(s) (e.g., letter of warning, stipulation)?  No  Yes

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide any information you believe relevant to the applicant's qualifications and fitness to practice midwifery:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SEAL

Signed: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

State Board: \_\_\_\_\_

Date: \_\_\_\_\_

Please return this form directly to:

Division of Corporations, Business and Professional Licensing  
Alaska Board of Certified Direct-Entry Midwives  
P.O. Box 110806  
Juneau, AK 99811-0806

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing  
Board of Certified Direct-Entry Midwives  
P.O. Box 110806, Juneau, Alaska 99811-0806  
(907)465-2580  
E-mail: [license@alaska.gov](mailto:license@alaska.gov)

## Certification of Completion of the Practical Skills List for Alaska CDM's

THIS FORM IS TO BE COMPLETED BY THE APPLICANTS PRIMARY PRECEPTOR TO VERIFY THAT THE APPLICANT HAS COMPLETED THE SKILLS LIST REQUIRED BY 12 AAC 14.210(f)

I, \_\_\_\_\_, certify that I have acted as the primary  
Primary Preceptor Name  
preceptor for \_\_\_\_\_. By my signature below, I verify that this apprentice  
Apprentice Name

has completed all of the practical skills listed on the PRACTICAL SKILLS LIST FOR ALASKA CERTIFIED DIRECT-ENTRY MIDWIVES.

I further certify that for each skill completed under the supervision of a secondary preceptor, I have received the form "Preceptor Verification of Practical Skills List for Alaska CDM's" (page 46 of the skills list) signed and notarized by the secondary preceptor, verifying that the skill(s) has been completed.

I am in possession of the completed skills list and agree to keep it as required by 12 AAC 14.210(f) and will make it available for the board's review upon request.

\_\_\_\_\_  
Primary Preceptor's Signature

Date: \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

NOTARY SEAL

\_\_\_\_\_  
Notary Signature

My Commission Expires: \_\_\_\_\_