

# APPLICATION FOR TESTING AND SUBSEQUENT CERTIFICATION

AS A

CERTIFIED NURSE MIDWIFE (CNM)



American Midwifery Certification Board ©  
849 International Drive, Suite 205  
Linthicum, MD 21090  
410-694-9424 Phone  
866-366-9632 Toll Free

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**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 *Information for Candidates* booklet? No  Yes**   
***If your answer is NO, or if no answer is given, AMCB will not process your application for certification.***

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:  
\_\_\_\_\_  
Street City State Zip Code

**Please notify AMCB if you relocate. Information regarding Certificate Maintenance will be sent to the above address unless AMCB Headquarters is notified in writing of new address.**

4. Name as it should appear on certificate (last name in lines 1 above and 4 must be identical):  
\_\_\_\_\_

5. Current telephone number: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Email address: \_\_\_\_\_

6. Type of programs in which you were educated as a registered nurse (basic RN):

- Not Applicable     Diploma     Associate     Baccalaureate     Masters  
 Practice Doctorate     Research Doctorate     Other Doctorate

7. Academic degrees /certificates received in addition to basic RN education, but prior to enrollment in your program: (Please do NOT indicate any credential that has not already been conferred.)

- Not Applicable     Baccalaureate     Post-masters certificate  
 Diploma     Post-baccalaureate certificate     Doctorate  
 Associate     Masters

8. Number of years of nursing practice before nurse-midwifery education: \_\_\_\_\_ years

9. What is your current practice setting:

- Not Applicable     Intrapartum     Other  
 Ambulatory     Medical/Surgery    Other Details: \_\_\_\_\_  
 Critical Care     Postpartum/Well NewBorn

10. Current registered nurse license:

States: \_\_\_\_\_

Numbers: \_\_\_\_\_

Expiration: \_\_\_\_\_

**Attach a copy of a current nursing license or statement from the state detailing the information in line 10 (either must indicate licensure is active as of the date of application).**

11. Type of program(s) in which you were educated as a nurse-midwife:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Not Applicable    | <input type="checkbox"/> Baccalaureate                                  | <input type="checkbox"/> Post-masters certificate |
| <input type="checkbox"/> Pre-certification | <input type="checkbox"/> Masters  | <input type="checkbox"/> Doctorate                |
| <input type="checkbox"/> Certificate       | <input type="checkbox"/> Certificate / also enrolled in Master's option |   |

Name of Midwifery program: \_\_\_\_\_

12. Previous Midwifery Experience: No  Yes

13. FNP: No  Yes

14. WHNP: No  Yes

15. Ethnic Identity: *The information regarding ethnic identity is for statistical purposes only and will not be considered in reviewing your application.*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Prefer not to respond     | <input type="checkbox"/> Asian/Pacific Islander  | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> African American / Black  | <input type="checkbox"/> Caucasian               | <input type="checkbox"/> Middle Eastern  |
| <input type="checkbox"/> American Indian / Alaskan | <input type="checkbox"/> East Indian / Pakistani | <input type="checkbox"/> Other: _____    |

16. 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 (check all that apply):
- |  |  |
|--|--|
| <input type="checkbox"/> Federal Agency        | <input type="checkbox"/> Health Care Organization          |
| <input type="checkbox"/> State Licensing Board | <input type="checkbox"/> National Professional Association |

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?  Yes  No

If your answer is YES to any part of question 16 above, please explain on a separate sheet of paper.

17. Have you ever taken the national certification examination before?  Yes  No  
If yes, attach documentation of the program most recently completed.

**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 Nurse-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 and e-mail confirmations are NOT acceptable.

**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:** \_\_\_\_\_

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, and a copy of RN licensure, active as of the date of application to:**

**American Midwifery Certification Board. (AMCB)  
849 International Drive  
Suite 205  
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:** \_\_\_\_\_

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

Yes     No

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.

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You will receive one complimentary primary source verification 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.

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**Name**

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**Address**

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**City**

**State**

**Zip Code**