APPLICATION FOR TESTING AND SUBSEQUENT CERTIFICATION AS A

CERTIFIED NURSE-MIDWIFE (CNM)

American Midwifery Certification Board ©
849 International Drive, Suite 120
Linthicum, MD 21090
410-694-9424 Phone
410-694-9425 Fax

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 fully understand 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 AMCB Portal Access

1. Name: _____
   Last First Middle

Address where certification card 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 of new address:*

2. Address Type: ○ Home ○ Work
3. Street Line 1: _____ 4. Street Line 2: _____
5. City: _____ 6. State: _____ 7. Zip Code: _____ 8. Country: _____
9. Preferred Phone Number: ○ Mobile ○ Home ○ Work
10. Mobile Phone: _____ 11. Home Phone: _____
12. Work Phone: _____ 13. Work Phone Extension: _____
14. Email Address: _____

PART II: Education Information

15. Identify all your academic degrees will have earned prior to taking the AMCB National Board Exam. 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 (please specify) _____

PART III: Doctoral Information

16. If you have identified that you hold a doctoral degree (question 16), please select the type of doctoral degree(s) youcurrently 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.
    - ☐ Doctorate of Nursing Practice (DNP) or Nursing Doctorate (ND)
    - ☐ DNS or DNSc
    - ☐ PhD (Nursing)
    - ☐ Doctorate, Public Health (Dr. PH) or DrPH
    - ☐ PhD, other than Nursing_____
    - ☐ Doctorate, other type (not a PhD)_____
    - ☐ Other_____

PART IV: Nursing Information

17. Specify additional RN education degrees. Check all that apply.
    - ☐ Diploma
    - ☐ Associate
    - ☐ Baccalaureate
    - ☐ Masters
    - ☐ Practice Doctorate
    - ☐ Research Doctorate
    - ☐ Other Doctorate (e.g. JD, MD)_____

18. Academic degrees/certificates received in addition to basic RN education, but prior to enrollment in your program. Check all that apply.
    - ☐ Diploma
    - ☐ Associate
    - ☐ Baccalaureate
    - ☐ Post-Baccalaureate
    - ☐ Masters
    - ☐ Post-Masters Certificate
    - ☐ Doctorate
    - ☐ N/A

19. Setting in which you practice nursing? Check all that apply.
    - ☐ Ambulatory
    - ☐ Critical Care (i.e. NICU, ICU, ED)
    - ☐ Intrapartum
    - ☐ Medical/Surgical
    - ☐ Postpartum/Well Newborn
    - ☐ Other Setting (please specify) _____

20. Number of years of nursing practice before nurse-midwife education. _____

PART V: Midwifery Information

21. Midwifery School Name: _____

22. Program Type:
    - ○ Precertification
    - ○ Certificate
    - ○ Baccalaureate
    - ○ Master's
    - ○ Certificate (also enrolled in Master's option)
    - ○ Post-Masters certificate
    - ○ Doctorate

23. Program Start Date: _____ 24. Program End Date: _____

25. Prior to your midwifery education program, did you have previous experience practicing midwifery?
    - ○ No
    - ○ Yes

26. What additional type of provider certification do you hold that enables you to provide women's health care? Check all that apply.
    - ☐ Adult Health Nurse Practitioner (ANP)
    - ☐ Family Nurse Practitioner (FNP)
    - ☐ Women's Health Care Nurse Practitioner (WHNP)
    - ☐ None
    - ☐ Other (please specify) _____

PART VI: Employment Information

27. Please provide the name of the PRIMARY state or US territory in which you work in the field of midwifery. If you do not work in the US or its territories identify the location in the space provided.

    _____

28. Please provide the 9-digit zip code of your primary practice location. If you are uncertain or if you do not wish to provide the last four, please provide at least the 5-digit code. _____

PART VII: Midwifery Licensure Information

29. Please identify the number of states in which you hold an active license (or are otherwise authorized) to practice midwifery.
    - ○ None
    - ○ 1
    - ○ 2
    - ○ 3
    - ○ 4
    - ○ 5
    - ○ 6
    - ○ 7
    - ○ 8
    - ○ 9
    - ○ 10 or more

30. If you are currently licensed to practice midwifery, please identify the name of the PRIMARY state or US territory where you are licensed to practice midwifery. If you are not licensed in the US or its territories please specify the location in the space provided. _____

31. If you are currently licensed to practice midwifery, please identify the pathway of which you gained licensure.
    - ○ PEP
    - ○ CPM/MEAC Accredited
    - ○ State Specific Licensure
    - ○ Educated outside the US
    - ○ N/A
    - ○ Other (please specify)_____

PART VIII: Registered Nurse Licensure Information

Please provide your Primary RN License number. You may add up to three license numbers below. *Attach a copy of a current nursing license or statement from the state detailing the information above (name, status, and expiration date must be visible).*

Primary RN License:

32. State: _____
33. Number: _____
34. Expiration Date: _____

Secondary RN License:

35. State: _____
36. Number: _____
37. Expiration Date: _____

Tertiary RN License:

38. State: _____
39. Number: _____
40. Expiration Date: _____

PART IX: Demographic Information

41. Date of Birth: _____

42. Sex:
    - ○ Male
    - ○ Female
    - ○ Transgender
    - ○ I choose not to respond

43. Race:
    - ○ American Indian or Alaska Native
    - ○ Asian
    - ○ Black or African American
    - ○ Indian/Pakistani
    - ○ Native Hawaiian or other Pacific Islander
    - ○ White or Caucasian
    - ○ I choose not to respond
    - ○ Other (please specify)_____

44. Ethnicity. Check one best applies to your ethnicity.
    - ○ Yes, Hispanic/Latino
    - ○ No, Not Hispanic/Latino
    - ○ I choose not to respond

45. Is English your primary language?
    - ○ No
    - ○ Yes

46. Are you able to provide midwifery services to patients in a language other than English? Check all that apply.
    - ○ No
    - ○ Yes, Spanish
    - ○ Yes, Mandarin Chinese
    - ○ Yes, other language (please specify) _____

47. 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

48. Would you be willing to be contacted by AMCB in the future regarding volunteer opportunities with our organization?
    - ○ No
    - ○ Yes

PART X: Background Check

49. 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: Federal Agency, State Licensing Board, Health Care Organization, and/or National Professional Association?
    - ○ No
    - ○ Yes

50. Check all that apply to the above question.
    - ☐ Federal Agency
    - ☐ State Licensing Board
    - ☐ Health Care Organization
    - ☐ National Professional Association
    - ☐ N/A

51. Are you presently charged with or have 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 50 and/or 52 above, please explain on a separate sheet of paper.

52. Have you ever taken the national certification examination before?
    - ○ No
    - ○ Yes

    If YES to number 53, attach documentation of the program most recently completed.

PART XI: Special Accommodation

53. 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 XII: 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 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: _____

Applicant Printed Name: _____

PART XIII: Complimentary Verification Letter

You will receive one complimentary primary source verification letter upon successful completion of the examination. You may have this letter emailed or mailed to another entity e.g. State Board of Nursing, OBGYN Practice, or hospital, by providing the necessary information below. Most applicants will have this letter sent to the State Board of Nursing or Midwifery Board where they are applying for licensure to practice.

_____

Name of the person or organization to send your complimentary verification letter

Check a delivery method for your complimentary verification letter: ○ Email ○ Mail

Email Address: _____

Mailing Address:_____

_____

PART XIV: Program Director Confirmation Required

Be advised that no exam application will be approved without written confirmation on official school letterhead, signed by your program director, that you have successfully completed a graduate degree and midwifery program requirements, including the date it was completed and your date of birth. Please note that the program director must email or mail confirmation to AMCB directly.

PART XV: 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*):

Card Number: _____

Expiration Date: _____ Security Code: _____

Name on Card: _____

Billing Address: _____

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