



MAINE STATE BOARD OF NURSING

158 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA, MAINE 04333-0158
(207) 287-1138

APPLICATION FOR LICENSE AS A CERTIFIED NURSE-MIDWIFE

DO NOT WRITE IN THIS SPACE

Application Received _____

Application Approved by Board of Nursing: _____

Fee: CC Cash Check MO _____

Chair

License Date _____

Executive Director

LICENSE NUMBER _____

Date

INSTRUCTIONS An applicant must submit to the Board of Nursing office the following:

1. Application form completed in **ink or typewritten**, with signature in applicant's handwriting;
2. Fee of \$100.00 in the form of Visa/MasterCard/Discover Card (credit card form enclosed), check or money order in U.S. funds, made payable to "Treasurer of the State of Maine";
3. Recent passport type photograph (2 x 2 and no more than two years old) enclosed with the application form;
4. Verification of authority to test directly from your certifying body (N/A if already certified);
5. Receipt verifying your scheduled exam date (N/A if already certified);
6. Verification of certification as a clinical-midwife directly from your certifying body; and
7. Final transcript(s) with degree(s) conferred directly from your advanced practice registered nurse program (if you have completed both a master's and postmaster's degree program, the office will need both transcripts).

FOR APPLICANTS WHO LEGALLY RESIDE IN ANOTHER COMPACT STATE AND HOLD A COMPACT LICENSE IN THAT STATE, the following items are required:

1. Complete verification of basic nurse nursing licensure from the original state of licensure (either through NURSYS at www.nursys.com if the state participated in NURSYS for nursing verification or request a paper verification from nonparticipating NURSYS states; and
2. Complete a basic nursing information form (enclosed).

YOU MAY NOT PRACTICE NURSING IN MAINE UNTIL YOU RECEIVE AUTHORIZATION FROM THIS OFFICE

THE APPLICATION FEE IS NOT REFUNDABLE

SECTION 1. PROFILE INFORMATION

FULL LEGAL NAME	FIRST	FULL MIDDLE OR "N/A"	MAIDEN	LAST
ANY OTHER NAMES EVER USED				
DATE OF BIRTH	/	/	PLACE OF BIRTH	CITY STATE
SOCIAL SECURITY NUMBER	-	-	PERSONAL EMAIL ADDRESS	
MAILING ADDRESS *This is considered your public contact address				
CITY	STATE	ZIP CODE	COUNTRY	
RESIDENTIAL ADDRESS (if different from above)				
PHONE NUMBER(S)	HOME	MOBILE	BUSINESS	
HIGH SCHOOL	NAME	LOCATION	DATE OF GRADUATION	/ /
G.E.D.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE OF G.E.D. DIPLOMA	/ /

SECTION II. DISCIPLINARY INFORMATION

PLEASE READ AND ANSWER EACH QUESTION CAREFULLY AND TRUTHFULLY:

NOTE: Answers found to be fraudulent may result in denial, fines, suspension, and/or revocation of a license.

- A. Has **any** licensing authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license, certificate or multi-state privilege held by you now or previously, or ever fined, censured, reprimanded, or otherwise disciplined you? YES NO
- B. Is there any complaint pending against your license in any state or jurisdiction including Canadian and foreign jurisdictions? YES NO
- C. Have you ever been disciplined for problems resulting from a physical illness or condition? YES NO
- D. Have you ever been disciplined for problems resulting from mental illness? YES NO
- E. Are you currently participating in a substance abuse and/or alcohol or drug treatment program or have been diagnosed with a substance abuse disorder which in any way currently affects or limits your ability to practice safely and in a competent and professional manner? YES NO
- F. Have you ever been disciplined for problems resulting from chemical dependency? YES NO
- G. For any criminal offense, including those pending appeal, have you: *(please select below all that apply)*
 - a. Been convicted of a misdemeanor?
 - b. Been convicted of a felony?
 - c. Pled nolo contendere, no contest, or guilty?
 - d. Received deferred adjudication?
 - e. Been placed on community supervision or court-ordered probation, whether or not adjudicated guilty?
 - f. Been sentenced to serve jail or prison time? Court ordered confinement?
 - g. Been granted pre-trial diversion?
 - h. Been arrested or have any pending criminal charges?
 - i. Been **cited** or charged with any violation of the law? *(other than parking tickets and/or traffic violations)*
 - j. Been subject of a court-martial; Article 15 violation; or received any form of military judgement/punishment/action? YES NO
- H. Are you currently the target or subject of a grand jury or government agency investigation? YES NO

NOTE: If you answered "YES" to questions A-G listed above, attach a letter of explanation that is dated and signed indicating the circumstances you are reporting to the Board. If you answered "YES" to questions G or H, you must also attach the document(s) showing the disposition of the case(s).

SECTION III. ADVANCED PRACTICE NURSING EDUCATION

SCHOOL OF PROFESSIONAL NURSING	NAME
ADDRESS	
DATE OF ENTRANCE	DATE OF GRADUATION
/ /	/ /
ACCREDITING AGENCY OF APRN PROGRAM (E.G. ACNM)	
Certificate <input type="checkbox"/> Baccalaureate <input type="checkbox"/> Masters <input type="checkbox"/> Doctoral <input type="checkbox"/> Post Masters <input type="checkbox"/>	

SECTION IV. LICENSURE HISTORY

Do you hold, or have you ever held a license to practice nursing (Registered Professional – RN) in the State of Maine? YES NO

If you have been issued an RN license, please enter: License Number: _____ and Expiration Date: ____/____/____

SECTION V. EMPLOYMENT INFORMATION

A. List employment in nursing for the past five years.

Name of Agency	City and State	Dates of Employment					
		FROM	/	/	TO	/	/
		FROM	/	/	TO	/	/
		FROM	/	/	TO	/	/

B. If you **have not** been employed in nursing in the last five years, please explain. _____

C. Are you currently employed as a Nurse-Midwife? YES NO

If yes, please specify: NAME ADDRESS PHONE NUMBER

D. Where in Maine do you plan to work?

NAME ADDRESS PHONE NUMBER

SECTION VI. NURSE MIDWIFE CERTIFICATION

Are you currently certified as a Nurse-Midwife by a national certifying body?

If YES indicate the specialty(ies), certifying body(ies), certification number(s), and expiration date(s): _____

If NO indicate name of qualifying examination(s) and date(s) scheduled to test: _____

SECTION VII. PHARMACOLOGY & PRESCRIPTIVE PRACTICE

A. Did you have a course in pharmacology in your nursing practitioner program? YES NO

IF YES, how many credits and/or contact hours? _____ (45 contact hours/3 credits required)

IF NO, *but pharmacology was integrated,* please have your program send a letter explaining how integration was accomplished and how much pharmacology was included. Please have your program include information regarding the following in its explanation:

1. Number of contact hours and/or credits (45 contact hours/3 credits required)
2. Applicable state and federal laws
3. Prescriptive writing
4. Drug selection, dosage, and route
5. Information resources
6. Clinical application of pharmacology related to specific scope of practice

IF NO, *but you have obtained contact hours or credits in pharmacology in a formal academic setting or non-credit continuing education offerings,* please provide certificates and documents that verify the offering covered in the information numbers 1-6 or have your program send official transcripts **directly** to the Board.

B. Have you prescribed in the last two years? YES NO New CNM Graduate _____

IF YES, please provide documentation from your current/former employer that you prescribed medications in the last two years.

IF NO, please provide the Board with documentation of 15 contact hours of recent (within the last two years) continuing education in pharmacology.

Have you prescribed in the last five years? YES NO N/A

IF NO, please provide the Board with documentation of 45 contact hours (3 credits) or recent (within the last two years) continuing education in pharmacology.

SECTION VIII. DECLARATION OF PRIMARY RESIDENCE

A. I declare that the State of _____ (state) is my primary state of residence as of ____/____/____ (date) and that such constitutes my permanent and principal home for legal purposes. (“Primary state of residence” is defined as the state of a persons declared fixed permanent and principal home for legal purposed; domicile.)

****If you have declared Maine as your primary state of residence, a criminal background check (CBC) must be completed through the Maine Department of Public of Safety (DPS) and the FBI based on a set of fingerprints provided to Identogo before your application will be processed. Register for fingerprinting online at <https://me.ibtfingerprint.com/>. If you do not register you will not be able to have your fingerprints taken. There is a one-time \$52 fee for this process.**

B. Upon licensure in Maine, in which state(s) do you intend to practice?

C. Are you currently employed in the U.S. Military (Active Duty) or in the U.S. Federal Government? YES NO

TAPE TOP ONLY

One recent photograph

Photo must be:

Full face view

Passport Type

← 2 x 2 only →

Clear and recognizable likeness

By my signature, I the undersigned, being duly sworn, say that I am the person referred to in this application for licensure in the State of Maine and hereby certify that the information provided on this application is true and accurate. By submitting this application, I affirm that I have complied with all requirements of the law, and that I have read and understand this affidavit and that the Maine State Board of Nursing will rely on this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension, or revocation of my license if this information is found to be false.

Signature of Applicant _____ Date _____



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BASIC NURSING INFORMATION FORM

To be completed by an Advanced Practice Registered Nurse who legally resides in, and holds a multistate license, in another compact state and has never been issued a Maine Registered Professional Nursing license.

Applicants Name: _____
(First) (Middle) (Last)

1. BASIC NURSING EDUCATION *(First Registered Nurse Program You Completed)*

School of Professional Nurse: _____

**If foreign prepared, transcript is required*

Address: _____

Date of Entrance: _____ Date of Graduation: _____ Length of Program*: _____

**If program is less than 2 years, please give details (i.e. If you have a previous degree): _____*

Diploma Associate Baccalaureate Masters Doctoral Certificate

2. LICENSURE HISTORY *(Original Registration)*

State/Country: _____ Year: _____ License Number: _____

If license in another country, what U.S. State were you originally licensed in?

State/Country: _____ License Number: _____

Verification of licensure is required from original U.S. state jurisdiction and country (if applicable) via NURSYS at www.nursys.com (NURSYS verification participating state) or paper document directly from country and/or state (non-participating NURSYS state).



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CREDIT CARD AUTHORIZATION FORM

Please Provide the Following:

We accept Visa/MasterCard/Discover Card

Credit Card # _____

Credit Card Expiration Date:

(mm/yy) _____

Your Name

(if not the Card Holder) _____

Card Holder's Name:

(as it appears on the Card) _____

Card Holder's Billing

Address _____

Card Holder's Signature _____

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRSA §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers, and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website. The mailing address is considered your public contact address.