NURSE-MIDWIFE LICENSE RENEWAL APPLICATION

INSTRUCTIONS: ***Applications must be postmarked by the 10th of the month your current CNM license expires.***

Please read this whole form carefully. When printing the application and with all documents submitted, please print one-sided.

Then, if you have questions, phone (505) 476-8907, or (505) 476-8866 OR
Email amber.montoya@state.nm.us or catherine.avery@state.nm.us

- *Nurse-Midwifery Certification with ACNM must be current.*
- *RN License: We will verify your NM RN license on the Board of Nursing website. If you have a RN license from another Nursing Compact state, you must enclose a copy of it with this application.*
- *CEUs: Enclose a copy of a certificate of attendance for all continuing education. Record individual courses in the* ***Continuing Education Units Requirement*** *section of this application. Refer to your recent renewal reminder email for instructions on opioid CME requirements.*
- *Fees: Enclose $100.00 check or money order made out to Public Health Division. If your application is not postmarked or electronically submitted by the 10th of the month of the current license's expiration date, you must include an additional $50.00 late fee (total: $150.00) or your application will not be processed.* ***Please write "Midwifery Licensure" on the check memo line.***
- *Sign, and enter the date, at the end of the application.*
- *Mail your application to this EXACT address*: →

New Mexico Department of Health
Public Health Division
PO Box 25307
Albuquerque, NM 87125
Account XXXXXX7789
ATTN: License Renewal

GENERAL INFORMATION

Name _____

Date of Birth_____ SSN _____

Home phone_____ Work phone_____

Mailing Address _____

City _____ State _____ Zip_____

E-Mail Address _____

Check or Money Order#_____ Amount_____ Date_____

List states/countries in which you have ever been licensed as a CNM _____

LICENSURE HISTORY

Have you ***EVER*** been named in a legal suit alleging misconduct, malpractice or negligence as a RN, CNM or other licensed health care provider?

No ___ Yes ___

If yes, where, when, and why? Answer on an additional sheet. (If you have given this information in a previous application, you need only write any update information.)

Have you ***EVER*** had a license as RN, CNM, or other licensed health care provider suspended or revoked, or have you been otherwise censured or disciplined by a licensing agency?

No ___ Yes ___

If yes, where, when, and why? Answer on an additional sheet. (If you have given this information in a previous application, you need only write any update information.)

The National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank will also be queried to find out if practitioners have adverse licensure actions, adverse clinical privilege actions, Medicare/Medicaid exclusions, civil and criminal convictions, or medical malpractice payments. False information given above could result in disciplinary action on your license.

QUALITY MANAGEMENT REQUIREMENT

PART A: PARTICIPATION IN AT LEAST ONE TYPE OF QUALITY MANAGEMENT DURING THE LAST 2 YEARS IS REQUIRED. CIRCLE THE TYPE(S) OF QUALITY MANAGEMENT YOU PARTICIPATED IN:

Enclose a copy of any related certificates.

A. Peer Review; the assessment and evaluation of CNM practice by other CNMs or other health care providers to measure compliance with established institutional or legal standards in the peer review process, a CNMs practice undergoes scrutiny for the purpose of professional self-regulation. Participation may be by being reviewed or by being a reviewer. (Example: chart review, case presentation).
B. Quality Assurance; monitoring structural, procedural and outcome indicators as they relate to accepted standards. (Example: data collection for study of a nurse-midwifery related topic such as episiotomies, or auditing cases related to an issue such as inductions)
C. Quality Improvement; modifying the process for providing care in order to improve outcomes. Modifications are based upon the measurement of parameters such as evidence-based best practices, patient satisfaction, clinical outcomes, and population-specific care, appropriate use of technology and resources, and access to care. (Example: writing or revising practice protocols)
D. Other (Describe below or on an additional page.)

***PART B*:** COMPLETE THE INFORMATION FOR EACH CIRCLED ITEM. USE ADDITIONAL SHEETS AS NEEDED.

1. Dates and times ----------

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2. Topic(s) reviewed, audited, presented, measured or written/revised, etc.:

---

3. Who participated in the activity?

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4. Describe your participation.

CONTINUING EDUCATION UNITS REQUIREMENT

ENCLOSE CERTIFICATES OF ATTENDANCE AND APPROVAL FOR ALL PROGRAMS; ALL CEU'S MUST BE APPROVED BY ONE OF THE FOLLOWING:

- Accreditation Council For Continuing Medical Education (ACCME);
- American College of Nurse Midwives (ACNM);
- American College of Obstetricians and Gynecologists (ACOG);
- American Academy of Physician Assistants (AAPA);
- American Academy of Nurse Practitioners (AANP);
- Nurse Practitioners in Women's Health (NPWH); or
- other clinician-level continuing education accrediting agencies approved by the department.

PART A**:** 15 CONTACT HOURS (1.5 CEU's) OF *PHARMACOLOGY RELATED* EDUCATION ARE REQUIRED FOR EACH RENEWAL PERIOD AND MUST HAVE BEEN GAINED WITHIN THE PREVIOUS TWO YEARS (i.e., from first day of your current licensed period to current expiration date).

What qualifies?

- If the accreditor specifies pharmacology hours on the certificate of attendance, those hours qualify.
- If hours of continuing education are accredited for pharmacologists, those hours qualify.
- If the topic is one that usually involves pharmacology, e.g. hypertension or HRT, those hour(s) qualify.
  - ☐ Unless the topic is designated on the certificate, include a syllabus or agenda that states the topic(s).
  - ☐ If the hours were part of a workshop or conference with breakout sessions, include a program and indicate which sessions you attended.

DATE	PROGRAM TITLE	SPONSOR	APPROVAL	HOURS

***PART B*:** 30 CONTACT HOURS (3 CEU'S) OF CONTINUING EDUCATION TOTAL ARE REQUIRED DURING EACH RENEWAL PERIOD. ENTER ADDITIONAL CONTACT HOURS TO TOTAL 30 HOURS INCLUDING THE PHARM CREDITS LISTED ABOVE**.**

DATE	PROGRAM TITLE	SPONSOR	APPROVAL	HOURS

ACCEPTED ALTERNATIVES TO CEU CREDITS

CIRCLE THE ALTERNATIVE, FILL IN /ENCLOSE REQUESTED INFORMATION. EACH ALTERNATIVE MAY BE USED ONLY ONCE AND MUST HAVE BEEN COMPLETED DURING THE PAST TWO YEARS.

****

1. Giving a presentation on a nurse-midwifery related topic that has CEU approval by any accreditor listed in the CEU section of this application. First presentation only.
**Enclose a copy of your agenda and proof of CEU approval*.
Equivalent: twice the number of contact hours approved for attendants.

TITLE _____ DATE _____

SPONSOR _____ LENGTH IN MINUTES_____

****

2. Completing an accredited university or college course directly related to nurse-midwifery.
**Enclose proof of attendance and passing grade*.
Equivalent: 15 contact hours per college/university unit.

INSTITUTION _____

COURSE TITLE _____

DATES ATTENDED _____

COURSE NUMBER _____ FINAL GRADE _____

****

3. Publishing an article on a nurse-midwifery related topic in a peer juried medical or midwifery journal, as sole or primary author.
**Enclose a copy of the article.*
Equivalent: 10 contact hours.

AUTHOR(s) _____

TITLE _____

JOURNAL _____

VOLUME_____ PAGES _____ DATE _____

****

4. Being primary preceptor for a nurse midwifery student.
**Enclose verification from an ACNM accredited nurse-midwifery school.*
Equivalent: 1 hour for each 10 hours of precepting completed.
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NMDOH Certified Nurse Midwives Workforce Survey
THIS ADDITIONAL INFORMATION IS REQUIRED BY THE NEW MEXICO HEALTH POLICY COMMISSION PURSUANT TO THE HEALTH INFORMATION SYSTEM ACT, SECTION 24-14A-1 ET SEQ. NMSA 1978.

New Mexico License Number: _____ Last Name: _____

I. DEMOGRAPHIC INFORMATION

Gender: ☐Male ☐Female ☐Decline ☐Other_____

Hispanic, Latino or Spanish Origin: ☐Yes ☐No ☐Decline

Race: Please select all that apply

☐White or Caucasian ☐Black or African American ☐Native American or Alaska Native

☐Asian or Pacific Islander ☐Decline ☐Other: _____

Native Language(s): _____

Other Proficient Language(s): _____

II. CURRENT WORK STATUS (Please select all that apply)

☐Practicing in New Mexico

☐Not actively practicing midwifery, but have an active license

☐Retired, but maintain an active license

☐Practicing midwifery in another state. Specify: _____

[If not working in NM, you may end the survey at this point.]

III. CURRENT ACTIVITIES

a. On average, how many hours per week do you practice in NM? _____

b. On average, how many weeks per year do you practice in NM? _____

c. Do you currently attend births (within the past year): ☐Yes ☐No

d. Approximately what percentage of your time was spent on the following activities in your practice in New Mexico? Percentages of all selected activities should total 100%.

_____ % Teaching or Precepting

_____ % Prenatal Care

_____ % Attend Deliveries

_____ % Outpatient Women's Health/Primary Care

_____ % Healthcare Administration

_____ % Research

_____ % Other. Please Specify:_____

IV. PRACTICE CHARACTERISTICS

a. Approximately what percentage of your time was spent in the following types of facilities for ***direct patient care***? Percentages of all selected activities should total 100%.

_____ % Hospital/Inpatient

_____ % Outpatient/Clinic

_____ % Home Births

_____ % Birthing Centers

_____ % Other. Please Specify:_____

b. Which best describes your practice size in your ***PRIMARY*** work setting? Please check all that may apply.

☐ Solo, Independent Practice

☐ Group of Same Specialty (OB/GYN). Specify Total Number of Other Independent Practitioners_____

☐ Multi-Specialty (OB/GYN and other) Group Practice. Specify Total Number of Other Specialists _____

☐ Other_____

c. Which best describes your ***PRIMARY*** practice's organization?

☐Independent Private Practice ☐Birthing Center ☐Private Health Center/Clinic

☐University ☐Hospital-group practice

☐Federal Qualified Health Clinic (FQHC) ☐Indian Health Service Clinic ☐Locum Tenens

☐ Public/Nonprofit Center/Clinic (non-FQHC) ☐ Other. Please specify: _____

d. Number of hospitals in New Mexico at which you have admitting privileges

☐None ☐One ☐Two ☐Three or more ☐Not applicable

V. PRACTICE DIFFICULTIES

a. Does your practice encounter any claim reimbursement issues for services rendered to patients?

☐No ☐Yes.

Please Explain_____

b. On next page, please mark to which services you currently experience difficulty in referring patients since your last licensure application. Please mark all that apply.

- ☐ Public Health Department
- ☐ Gynecologist /Obstetricians
- ☐ Nutritionist /Dieticians
- ☐ Geneticists
- ☐ Lactation Consultants
- ☐ Specialists (Perinatal or Fetal Medicine)
- ☐ **(WIC)** The Special Supplemental Nutrition Program for **Women, Infants, and Children**
- ☐ Behavioral/Mental Health
- ☐ Intimate Partner Violence
- ☐ Homeless Shelter
- ☐ Tobacco/Nicotine Cessation
- ☐ Substance Abuse
- ☐ Medicaid
- ☐ Other. Please Specify_____
- ☐ Home Visitation Program
- ☐ Early Intervention (Part C)
- ☐ Newborn Screening
- ☐ **(TANF)** Temporary Assistance for Needy Families
- ☐ **(LIHEAP)** Low-Income Home Energy Assistance Program
- ☐ **(SNAP)** Supplemental Nutrition Assistance Program

For any services marked, please describe the barrier(s):

_____
_____
_____
_____

VI. PRACTICE PLAN OR CHANGES

a. Have you changed jobs in the last two years (i.e. since last renewal)? ☐ Yes ☐ No

b. Did you encounter any difficulties or barriers when you searched for this new position? ☐ Yes ☐ No

c. What barriers to employment did you encounter when making this job change? Please describe why this was a barrier(s)

_____
_____
_____
_____

d. In the next 2 years (24 months), do you plan to? (Please select all that apply):

☐ Retire from patient care ☐ Move my practice to another geographic location in New Mexico

☐ Significantly reduce patient care hours ☐ Move my practice out of New Mexico ☐ None of the above

e. If you are retiring, moving or reducing patient care hours in the next 2 years (24 months), what factors led to that decision? Please select all that apply.

☐ Age ☐ Health ☐ Geographic preference ☐ Practice Environment ☐ Lack of Job Satisfaction

☐ Gross Receipts Tax ☐ Increasing Administrative/Regulatory Burden ☐ Reimbursement Issues

☐ Better Pay ☐ Not applicable ☐ Other. Please Explain _____

Do you have any other comments/feedback that you would like the Maternal Health Program to know about?

_____

_____

_____

All Information is complete and accurate.

_____ _____

Signature *Date*

NEW MEXICO
DEPARTMENT OF
HEALTH

HSC/LA Credentials
PO Box 92200
Albuquerque, NM 87199-2200
1-866-908-0070 (Toll-free)
505-346-0288 (Facsimile)
cvs@nmhsc.com

Credentialing Itemized Request Form

Customer Name: New Mexico Department of Health/Public Health Division

Requested By: MCH Program Request Date (by MCH): _____

✓ I agree to pay the itemized fee per the current contract, plus additional verification fees incurred. *Verification fees will be passed though at cost.*

Please place a check mark next to the verification service you are requesting:

NPDB/HIPDB Query ✓

In the section below, please provide as much information on the practitioner this request relates to. For NPDB/HIPDB queries, this will ensure a more accurate and detailed report on the practitioner:

Practitioner's Name: _____
Last *First* *MI* *Title, e.g. M.D.*

Gender: _____ Social Security Number: _____

Date of Birth: _____ DEA Number: _____

Office Address: _____
Street Address

_____
City *State* *Zip Code*

License Number: _____ License Type (e.g. RN, CNM): _____ License State: _____
License Number: _____ License Type (e.g. RN, CNM): _____ License State: _____
License Number: _____ License Type (e.g. RN, CNM): _____ License State: _____

Board Specialty (if applicable): _____

Midwifery School Program: _____ Graduation Date _____

*Itemized verifications are typically completed within 1-2 business days of receipt of the **completed** form and signed release.*

HOSPITAL SERVICES CORPORATION
CREDENTIALS VERIFICATION SERVICE
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION
("Release")

Authority to Release: I have applied to participate as a provider for _____

New Mexico Department of Health/Public Health Division

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated Hospital Services Corporation's Credentials Verification Service ("HSC") as their agent. I consent to complete disclosure by the recipient of this release to HSC of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon state or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider, or (3) to participate in the common recredentials program, if applicable.

This Release does not authorize HSC to disclose information about my qualifications to any claimant. If a claimant requests information from HSC about me or if a subpoena duces tecum is served upon HSC seeking information about me, which is in HSC's possession, I understand I will be notified immediately. If I direct HSC to resist the subpoena, I hereby agree to indemnify and hold harmless HSC, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC and is received within five years of its date.

The certain definitions used in this Release and set forth on the following page of this application are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to HSC. PHOTOCOPY BOTH PAGES OF THIS FORM.

Signature stamps and date stamps are not acceptable.

_____
Applicant Signature

_____ _____
Printed Name Date (do not type)

DEFINITIONS of terms used in this Designation and Authorization for Release and Redisclosure of information.

"Health Care Entity" is the Health Care Entity on the front of this form.

The "Health Care Entity's Authorized Representatives" include any management or quality assurance companies hired by the Health Care Entity or HSC; the Health Care Entity's Board, staffs, committees, CEO, administrator medical director or other employees of the Health Care Entity whose performance of duties requires access to information about my qualifications; consultants whose contract with the Health Care Entity requires access to information about my qualifications; any independent credentialing services including HSC; and the Health Care Entity's attorneys and insurers.

"Credentials and Privileges" means all information regarding my qualifications, my standing with the Health Care Entity, and my right to provide healthcare services at or through the Healthcare Entity. It also includes any limitations imposed upon my right to provide healthcare services and any final disciplinary action taken by the Health Care Entity with regard to my provision of healthcare services at or through the Healthcare Entity.

"Credentialing Verification Service" is the service operated by Hospital Services Corporation. HSC may be required as a condition of certification by the National Committee for Quality Assurance (NCQA) to permit audits of HSC's system. The person providing this Release acknowledges that these audits are conducted solely for the purpose of certifying the credentialing verification service, and all information utilized by the NCQA is treated as confidential.

"Claimant" means any person, guardian, or personal representative who is asserting an administrative or legal claim against the person providing this release based in whole or in part upon allegations that the person providing this release has violated any state or federal law or regulation or has committed medical malpractice.

"Medical Staff or Provider Panel" is to be interpreted broadly to include any group of healthcare providers howsoever designated, who are authorized to provide healthcare services to patients, insureds, beneficiaries, members, or enrollees of a healthcare plan.

"Third Parties who have a need to know" include, but are not limited to governmental agencies and boards; organizations, associations, partnerships, corporations; other hospitals and clinics; managed care organizations ("MCO's"), Independent Practice Associations ("IPA's"), Managed Service Organizations ("MSO's"), Physician Hospital Organizations ("PHO's"), Preferred Provider Organizations ("PPO's"), Health Maintenance Organizations ("HMO's"), medical foundations, insurance underwriters, employer or employee sponsored ERISA health plans, health care alliances, or others with whom I am negotiating a health care provider agreement, presently have a health care provider agreement or with whom the Health Care Entity identified on the front page of this authorization (or the Health Care Entity's Authorized Representatives) is negotiating a health care provider agreement or has health care provider agreement in which I have or will acquire an interest.

"Common Recredentials Program" has been developed to allow this application to be utilized for multiple requesting customers to both expedite processing and reduce provider paperwork.