NEW MEXICO PUBLIC HEALTH DIVISION, MATERNAL HEALTH PROGRAM,
PO BOX 26110, SANTA FE, NM 87502 FAX: (505) 476-8995

Application for Midwifery Instructor/Preceptor

Legal Name: _____ NM LM License # _____

Address: _____ Phone: _____

City: _____ State/Country: _____ Zip: _____

Employer_____ Phone: _____

Address: _____

City: _____ State/Country _____ Zip: _____

Check all licenses you have, **and enclose a copy** of each license other than the NM LM license.

a. Out of State Licensed Midwife _____ c. Licensed Physician _____

b. Certified Nurse-Midwife _____ d. Licensed PA/Midwife _____

Expiration date of license(s) _____

Total length of active Midwifery/Obstetric practice _____

Location(s) of deliveries currently: Check all that apply.

Home Birth _____ Birth Center _____ Hospital _____

Average number of midwifery/obstetric clients you see per year _____

I hereby certify that this application contains no willful misrepresentation and the information is true and complete to the best of my knowledge and belief. I further certify that I have read the New Mexico Regulations Governing the Practice of Licensed Midwifery. I will assist my apprentice(s)/student(s) to meet the requirements for becoming (a) New Mexico Licensed Midwife(s). I agree to retain ultimate responsibility for my apprentice(s)/midwifery student(s) clients' care.

_____ _____

Signature Date