

LICENSURE REQUIREMENTS

- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$80.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- National Criminal Background check supported by fingerprints. This report **MUST** be sent directly from the Department of Attorney General (AG) to the RI Board of Nursing. For information on this process please visit <http://www.riag.ri.gov/BCI>
- Official transcript from the school of midwifery, submitted by the college/school/university, directly to the Board. Transcript must include date of completion, graduation date and degree.
- Letter of certification directly from the American Midwifery Certification Board (AMCB) or North American Registry of Midwives (NARM)
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)
- If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Rhode Island Controlled Substance Registration (CSR) - Application Fee - \$200.00

- Completed Rhode Island Uniform Controlled Substances Act Registration Form (CSR) enclosed in this application to be used for that purpose.

In order to dispense, prescribe, store, or order controlled substances, **you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.** After you obtain your Rhode Island CSR you must apply for a federal DEA Number. That DEA number must be registered to a RI Business Address. An application for the federal DEA Number can be obtained by contacting DEA: DEA Phone Number (617) 557-2200. Web Site: http://www.dea diversion.usdoj.gov/drugreg/reg_apps/

Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

License Certificates

RIDOH will be providing wallet license cards **ONLY** on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



State of Rhode Island Advisory Council on Midwifery

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., Dr., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."

3. Gender

 Male Female

4. Date of Birth

Month

Day

Year

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Home Phone

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Business Phone

Extension

Business Fax

13. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

1. Are there any charges or investigations pending, in any state, against you? Yes No

2. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? Yes No

3. Have you ever had any disciplinary action(s) taken, or is any pending against your license to practice nursing, or any other licenses, registrations or certifications that you hold; or are any complaints pending in any state? Yes No

Note: If you answered "yes" to any of these questions you must submit a written explanation.

14. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Advisory Council on Midwifery any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as nurse in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Advisory Council on Midwifery of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)



Rhode Island Advisory Council on Midwifery

Room 103, Three Capitol Hill

Providence, RI 02908-5097

(401) 222-5700

Substitute forms are not acceptable - This form may be duplicated as needed.

INTERSTATE VERIFICATION FORM - ORIGINAL STATE OF LICENSURE

I am applying for a license to practice as a midwife in the State of Rhode Island. The Rhode Island Advisory Council on Midwifery requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Advisory Council on Midwifery at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE MIDWIFERY BOARD

| | | |
|----------------------------------------------------------------------------------------------------------------------|-----------------------|------------------|
| License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed | Original Date Issued: | Expiration Date: |
|----------------------------------------------------------------------------------------------------------------------|-----------------------|------------------|

Questions:

1. Has this midwife ever been investigated by your Board? Yes No

2. Has this midwife incurred any disciplinary proceedings in your state, or is any action pending? Yes No

3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No

4. Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____



Please return directly to the Board at the above address. Thank you for your prompt cooperation.



Rhode Island Advisory Council on Midwifery

Room 103, Three Capitol Hill

Providence, RI 02908-5097

(401) 222-5700

Substitute forms are not acceptable - This form may be duplicated as needed.

INTERSTATE VERIFICATION FORM - OTHER STATES OF LICENSURE

I am applying for a license to practice as a midwife in the State of Rhode Island. The Rhode Island Advisory Council on Midwifery requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Advisory Council on Midwifery at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE MIDWIFERY BOARD

| | | |
|----------------------------------------------------------------------------------------------------------------------|-----------------------|------------------|
| License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed | Original Date Issued: | Expiration Date: |
|----------------------------------------------------------------------------------------------------------------------|-----------------------|------------------|

Questions:

- Has this midwife ever been investigated by your Board? Yes No
- Has this midwife incurred any disciplinary proceedings in your state, or is any action pending? Yes No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
- Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____



Please return directly to the Board at the above address. Thank you for your prompt cooperation.

PLEASE KEEP FOR YOUR RECORDS:

IMPORTANT INFORMATION

Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license, Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances", for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities and practitioners with prescriptive privileges may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the US Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply online for the DEA Registration at the following web site:

www.dea diversion.usdoj.gov/drugreg/reg_apps/index.html

or by contacting the Drug Enforcement Administration at the following location:

Registration Unit
US Drug Enforcement Administration
JFK Federal Building
15 New Sudbury Street
Boston, MA 02203-0131
1-888-272-5174

Call the Drug Enforcement Administration to check on the status of a pending DEA Registration. **A copy of the DEA Registration must be provided to the BOARD within 60 days of its issuance by the DEA.**

PLEASE NOTE: Prescriptions in Schedules III, IV, and V cannot be written for more than one hundred (100) dosage units. A "dosage unit" is defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon or an oral liquid. Prescriptions in Schedule II may be written for up to a 30-day supply, with a maximum of two hundred fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

The Rhode Island Uniform Controlled Substances Act can be accessed at the following website:

<http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm>

*** Rhode Island Prescription Monitoring Program - (RIPMP) ***

The RIPMP is a database that allows you to view patient's prescription history prior to your writing a prescription for them.

Once your RI Controlled Substances Registration is issued we will email a user id and temporary password to the email address that you provided on the CSR form. RI Law requires that all prescribers of controlled substances be registered with the RIPMP. It is important to make sure your email address is current with the Department.

It is the Department's expectation that you utilize this valuable tool that not only protects you as a prescriber but more importantly protects your patients.

Please visit our website for more information about the program and expectations.

<http://www.health.ri.gov/programs/prescriptionmonitoring/>