

Draft

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(Forms and Instructions)

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ARKANSAS DEPARTMENT OF HEALTH
Women's Health
Application for Lay Midwifery Apprentice Permit

Draft

Last Name		First	Middle	Social Security Number		Date
Street		City		State		Zip
Mailing Address, if different						
Home Phone ()		Business Phone ()		Other Phone (cellular, pager, etc.) ()		
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Have you attended school, been licensed, or certified under a different name? <input type="checkbox"/> Yes If yes, what name(s) _____ <input type="checkbox"/> No				
Highest Grade Completed	Date Completed	Name of High School		Address	State	Zip
College or Vocational Training Name and Address of School		Dates Attended		Total Credit/ Clock Hours	Date of Diploma Or Certificate	
		From To				
		From To				
		From To				
If you are not a high school graduate, do you Have an equivalency certificate?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, from where _____			Date
Other Licenses Name of Trade or Profession		State		License Number		Expiration Date
Have you ever had a license revoked in any health-related field? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____ _____ _____			Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____ _____ _____			

I certify that all information given on this application is true and accurate.

 Signature of Applicant

 Date

 Type or print the application and check thoroughly before submitting. An incomplete application will delay processing.

**ARKANSAS DEPARTMENT OF HEALTH
Women's Health
Application for Lay Midwifery Apprentice Permit**

Draft

The following documentation must be included with the application:

1. A copy of your high school diploma or equivalent.
2. Current documentation of a negative TB skin test, negative chest X-ray, or a valid health card.
3. Proof of rubella immunization or immune status.
4. Current certification by American Red Cross or American Heart Association to provide cardiopulmonary resuscitation to adults and infants.
5. Preceptor-Apprentice Agreement(s) signed by the supervising Midwife/Preceptor.

Mail all forms and attachments to:

FREEWAY MEDICAL BUILDING
AR DEPT OF HEALTH, WOMEN'S HEALTH
5800 WEST 10TH, SUITE 401
LITTLE ROCK, AR 72204

ARKANSAS DEPARTMENT OF HEALTH

Women's Health

Apprentice Permit Renewal

Draft

Last Name	First	Middle	Date of Birth	Gender o Male o Female	Date
<i>It is your responsibility to notify us of any change in name or address</i>			Social Security Number		
Address (include Street, City, State, Zip)				Home Phone ()	
				Business Phone ()	
Mailing Address, if different from above				Other Phone (pager, etc.) ()	
Other Licenses Now Current Name of Trade or Profession		State	License Number		Expiration Date
Have you ever had a license revoked in any health-related field? o Yes o No If yes, specify _____ _____		Have you ever been convicted of a felony? o Yes o No If yes, specify _____ _____			
<p>INSTRUCTIONS</p> <p>Type or print the application and review thoroughly before submitting. An incomplete application will delay processing. The following documentation must be included with the application:</p> <ol style="list-style-type: none"> 1. Copy of certificate in Cardio-Pulmonary Resuscitation (infant and adult) showing expiration date. 2. Current documentation of a negative TB skin test, negative chest x-ray, or a valid health card. 3. Current Preceptor-Apprentice Agreement. 4. Current Clinical Evaluation for Apprenticeship: <ol style="list-style-type: none"> a. Clinical Experience Documentation for Births as an Active Participant b. Clinical Experience Documentation for Births as a Primary Midwife c. Documentation of Acquisition of Clinical Knowledge and Skills d. Preceptor Verification Form for Licensed Midwife Application <p align="center">Mail all forms and attachments to:</p> <p align="center"> FREEWAY MEDICAL BUILDING AR DEPT OF HEALTH, WOMEN'S HEALTH 5800 WEST 10TH, SUITE 401 LITTLE ROCK, AR 72204 </p>					

ARKANSAS DEPARTMENT OF HEALTH
Women's Health
Application for Lay Midwifery License

Draft

Last Name		First	Middle	Social Security Number		Date
Street		City		State		Zip
Mailing Address, if different						
Home Phone ()		Business Phone ()		Other Phone (cellular, pager, etc.) ()		
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Have you attended school, been licensed, or certified under a different name? <input type="checkbox"/> Yes If yes, what name(s) _____ <input type="checkbox"/> No				
Did you graduate High School? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, do you have a GED or High School Equivalency? <input type="checkbox"/> Yes <input type="checkbox"/> No From Where? _____ Date Obtained? _____						
Highest Grade Completed	Date Completed	Name of High School		Address	State	Zip
College or Vocational Training Name and Address of School		Dates Attended		Total Credit/ Clock Hours	Date of Diploma Or Certificate	
		From To				
		From To				
		From To				
Other Licenses Name of Trade or Profession		State		License Number		Expiration Date
Have you ever had a license revoked in any health-related field? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____ _____				Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify _____ _____		
Practical Experience	As Active Participant	As Primary Midwife	Out of Hospital Births	Hospital Births	Supervisor	
Management of Labor and Births						
Initial Prenatal Exams						
Prenatal Exams						
Newborn Evaluation						
Postpartum Evaluations 0 to 5 Hours Postpartum						
Postpartum Evaluations 24 to 72 Hours Postpartum						
Births with ≥4 prenatal exams, birth attendance, newborn exam, and LM-LM Application postpartum exam						

**ARKANSAS DEPARTMENT OF HEALTH
Women's Health
Application for Lay Midwifery License**

Draft

The above practical experiences were performed under the supervision of the following individuals:

Full Name and Title of Supervisor	Complete Mailing Address

I certify that all information given on this application is true and accurate.

Signature of Applicant

Date

*Notarize here if you are an Apprentice applying for the Lay Midwife License

Type or print the application and check thoroughly before submitting. An incomplete application will delay processing.

The following documentation must be included with the application:

1. *Copy of High School Diploma, GED Certificate or highest degree obtained.
2. Current documentation of a negative TB skin test, negative chest X-ray, or a valid health card.
3. *Date of Rubella Immunization or documentation of rubella immune status.
4. Current certification by American Red Cross or American Heart Association to provide cardiopulmonary resuscitation to adults and infants.
5. Documents of completion of the clinical requirements by either:
 - a. Clinical Experience Documentation for Births as Primary Midwife Form, Preceptor Verification Form for Licensed Lay Midwife Application and Documentation of Acquisition of Clinical Knowledge and Skills (completed by each supervising Midwife) documenting the minimal practice experience requirements. (Notary Required) or
 - b. Verification of attainment of the Certified Professional Midwife credential in the form of a letter from the North American Registry of Midwives or a notarized copy of your CPM certificate.

* Arkansas Apprentices that have provided this information to the Health Department with apprentice application will not be required to resubmit these items.

Mail all forms and attachments to:

FREEWAY MEDICAL BUILDING
AR DEPT OF HEALTH, WOMEN'S HEALTH
5800 WEST 10TH, SUITE 401
LITTLE ROCK, AR 72204

ARKANSAS DEPARTMENT OF HEALTH
Women's Health
Midwife License Renewal

Draft

Last Name	First	Middle	Date of Birth	Gender o Male o Female	Date
<i>It is your responsibility to notify us of any change in name or address</i>		Midwife License Number		Social Security Number	
Address (include Street, City, State, Zip)				Home Phone ()	
				Business Phone ()	
Mailing Address, if different from above				Other Phone (pager, etc.) ()	
College/Vocational Training/ Continuing Education since last application (attach copy of diploma/certificate)	Name and Address (City/State) of School or Provider of Continuing Education		Dates Attended	Total Credits/ Clock Hours/ Contact Hours	Date of Diploma Or Certificate
			From To		
			From To		
			From To		
			From To		
			From To		
			From To		
Other Licenses Now Current Name of Trade or Profession		State	License Number		Expiration Date
Have you ever had a license revoked in any health-related field? o Yes o No If yes, specify _____ _____ _____			Have you ever been convicted of a felony? o Yes o No If yes, specify _____ _____ _____		

INSTRUCTIONS

Type or print the application and review thoroughly before submitting. An incomplete application will delay processing. The following documentation must be included with the application:

1. Copy of certificate in Cardio-Pulmonary Resuscitation (infant and adult) showing expiration dates.
2. Current documentation of a negative TB skin test, negative chest x-ray or a valid health card.
3. Documentation of hours of continuing education obtained (LMW Reg. 301.02)

Mail all forms and attachments to:

FREEWAY MEDICAL BUILDING
 AR DEPT OF HEALTH, WOMEN'S HEALTH
 5800 WEST 10TH, SUITE 401
 LITTLE ROCK, AR 72204

Preceptor-Apprentice Agreement

Draft

Apprentice's name _____

To receive an Apprentice Permit, the apprentice must file an Application for Apprentice Permit and submit a signed Preceptor-Apprentice Agreement. The preceptor is responsible for the training of the apprentice and for supervision of the apprentice's performance as an assistant or primary midwife in the attainment of the required clinical experiences and demonstration of skills. The primary preceptor should provide instruction prior to the performance of clinical skills, and should sign the majority of the required clinical experiences and skills. Other qualified preceptors may sign for some of the required clinical experiences and skills.

Should the Preceptor-Apprentice Agreement be terminated by either party, it is the responsibility of both parties to notify the Department of Health. An apprentice may not continue to perform under any other qualified preceptors until a signed Preceptor-Apprentice Agreement is on file with the Department.

Preceptors must be an Arkansas licensed midwife or certified nurse-midwife, or if outside of Arkansas, preceptors must be licensed by the state of residency as a direct-entry midwife or certified nurse-midwife, or have a Certified Professional Midwife credential from the North American Registry of Midwives.

Preceptor Information:

Name _____

Address _____

City _____ State _____ Zip _____

Phones: (h) _____ (c) _____

Licensed by (state) _____ date of expiration _____

Or CPM number _____ date of expiration _____

In practice as a primary midwife since _____ total number of births _____

If not licensed in Arkansas, provide notarized copy of state license or CPM certificate, or have a verification letter sent by NARM.

I agree to provide training in all of the required clinical knowledge and skills, and to supervise by direct, on-site, supervision, all clinical experiences that will have my signature on the clinical documentation experience forms for:

Apprentice's signature _____ date _____

Signature of Preceptor _____ date _____

Documentation of Acquisition of Clinical Knowledge and Skills

Instructions for the Documentation of Clinical Experiences:

Draft

All apprentices must have a Preceptor-Apprentice agreement on file with the Department of Health. This preceptor is responsible for the training of the apprentice and for the majority of the required clinical experiences. Other midwives licensed in the state of Arkansas may sign for some of the clinical experiences. If any preceptor not licensed in the state of Arkansas is also a signer of any clinical experiences, that preceptor must have a Preceptor-Apprentice agreement on file with the Department. Any preceptor who signs on any portion of the Application must also be identified on the Preceptor Form included with the application.

The dates from the first assist to the final primary birth should encompass at least one year.

Preceptors are expected to sign the documentation forms at the time the skill is performed competently. Determination of “adequate performance” of the skill is at the discretion of the preceptor, and multiple demonstrations of each skill may be necessary. Documentation of attendance and performance at births, prenatals, postpartums, etc., should be signed only if mutually agreed that expectations have been met. Any misunderstanding regarding expectations for satisfactory completion of experience or skills should be discussed and resolved as soon as possible.

The preceptor is expected to provide adequate opportunities for the apprentice to observe clinical skills, to discuss clinical situations away from the clients, to practice clinical skills, and to perform the clinical skills in the capacity of a primary midwife, all while under the direct supervision of the preceptor. This means that the preceptor should be physically present when the apprentice performs the primary midwife skills. The preceptor holds final responsibility for the safety of the client or baby, and should become involved, whenever warranted, in the spirit of positive education and role modeling.

Twenty (20) of the 75 prenatal exams are required to be initial exams and include the Midwife’s prenatal exam, initial interview and history (Regulation 402.3).

Births as an Active Participant are births where the apprentice is being taught to perform the skills of a midwife. Charting, other skills, providing labor support, and participating in management discussions may all be done in Active Participant births in increasing degrees of responsibility. Catching the baby should be a skill that is taught towards the end of the active participant period, but not counted as a supervised primary. The apprentice does not have to perform all skills at every birth in this category, but should be present throughout labor and birth and should perform at least some skills at every birth. The apprentice should complete most of the active participant births before functioning as Primary Midwife under supervision.

Births as Primary Midwife under supervision means that the apprentice demonstrates the ability to perform all aspects of midwifery care to the satisfaction of the preceptor, who is physically present and supervising the apprentice’s performance of skills and decision making. Some skills at these births may be performed by the preceptor or other midwives/apprentices, but the catching of the baby, most skills, and labor management should be performed by the apprentice who is claiming the birth as a primary birth under supervision.

****It is recommended that the apprentice make blank copies of all forms in the Application in the event that more space is needed for documentation of clinical experience, or when more preceptors are involved.**

Documentation of Acquisition of Clinical Knowledge and Skills

Clinical Experience Documentation for Births as an Active Participant

*see Preceptor-Apprentice Documentation Information prior to signing this form

Draft

Name of Apprentice _____

Client Initials	Assist at Initial Midwife Exam	Number of Additional Prenatals	Assist at Birth	Date of birth	Place of birth	Assist Newborn Exam	Number of Postpartum Exams	Supervising Midwife's Signature
Example	Yes	4	Yes	1/3/06	home	Yes	2	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
Minimum required			20					
Your numbers								

There are no minimum numbers for any clinicals except assisting at birth, however, it is expected that the supervising midwife will provide training both outside of and during the performance of these other clinicals. The apprentice should provide the number of clinical experiences at which she assisted for each client listed. More than twenty spaces are provided in case some clinicals are performed on clients for which the apprentice does not attend the birth. Put a "yes" or "no" in columns unless a number, date, or other information is required. Do not leave spaces blank. Place of birth: indicate home, birth center, or hospital. Transports may count as an assist if the apprentice assisted during labor at home or birth center prior to transport. There may be a period of training where the apprentice observes but does not perform assistant activities at clinical experiences. Observations should not be documented as assists.

Documentation of Acquisition of Clinical Knowledge and Skills

Clinical Experience Documentation for Births as Primary Midwife

*see Preceptor-Apprentice Documentation Information prior to signing this form

Draft

Name of Apprentice _____

Client Initials	Perform Initial Midwife Exam	Number of Additional Prenatals	Manage Labor and Birth	Date of birth	Place of birth	Perform Newborn Exam	Number of Postpartum Exams	Supervising Midwife's Signature
Example	Yes	8	Yes	1/3/06	home	Yes	2	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
Minimum required	20	55	20			20	40	
Your numbers								

The apprentice should provide the number of clinical experiences at which she assisted for each client listed. More than twenty spaces are provided in case some clinicals are performed on clients for which the apprentice does not attend the birth. Put a “yes” or “no” in columns unless a number, date, or other information is required. Do not leave spaces blank. For at least three clients, the apprentice should have provided a minimum of 4 prenatal, birth, newborn, and 2 postpartum exams.

Place of birth code: please indicate home, birth center, or hospital. **Transports to the hospital may not count toward the 20 required primary births, but may be documented for prenatal exams, etc.**

Documentation of Acquisition of Clinical Knowledge and Skills

Draft

Apprentice's name _____

The following skills must be documented by a qualified preceptor as being competently performed by the apprentice. **Performance of the skills includes a demonstration and/or verbal discussion of the knowledge implied by the performance of the skill. Please indicate “by discussion” if skill is not performed.**

The preceptor should **date and initial** each line of any skill she is verifying. More than one preceptor may sign in order to complete the form. All preceptors who sign should also be listed on the Preceptor Verification Form.

General Skills

Demonstrates use of universal health precautions relevant to midwifery care _____

Demonstrates appropriate application of aseptic and sterile technique _____

Demonstrates thorough and accurate documentation of care _____

Pharmacology

Demonstrates knowledge of the benefits and risks of the following and refers for prescription and administration when indicated:

Rh Immune Globulin (RhoGam) for an Rh negative mother _____

Vitamin K & erythromycin for the newborn _____

Pitocin _____

Safe use, care, and transport of oxygen _____

Prophylaxis for Group B Strep _____

Postpartum Rubella immunization when non-immune _____

Antepartum

Assessment Skills:

Basic health history/OB and gynecological history/family history _____

Obtains diet history and provides nutritional education _____

Obtains interval updates of medical history _____

Evaluates general appearance _____

Obtains weight and height _____

Assesses maternal weight gain _____

Vital signs: temp, pulse, respirations, blood pressure _____

Urine testing for glucose, protein and nitrites _____

Examination of the skin for color and appearance _____

Examination of the pupils, whites and conjunctiva of the eyes _____

Examination of the thyroid gland for enlargement _____

Examination of lymph glands of the neck and underarm for enlargement _____

Auscultates heart for rate and rhythm _____

Auscultates lungs for abnormal breath sounds _____

Percusses the costovertebral angle for pain _____

Speculum examination of the vagina for color, discharge, leakage of fluid _____

Identifies position, presentation, lie of fetus (Leopold's maneuvers) _____

Assessment of Fetal Heart Rate auscultated by fetoscope or doppler _____

Identifies pelvic landmarks, assesses pelvis _____

Measurement of fundal height _____

Documentation of Acquisition of Clinical Knowledge and Skills

Draft

Estimates fetal size _____
Lower extremities for varicosities _____
Edema of face legs and hands _____
Determines estimated due date _____
Assesses well-being _____

Intervention Skills:

Evaluates knowledge of self- breast exam techniques _____
Instruction of clean catch urine specimen _____
Recognizes the indications for genetic counseling and refers as appropriate _____
Understands and applies knowledge of good eating practices _____
Evaluates and makes recommendations for discomforts of pregnancy _____
Demonstrates knowledge and application of ADA Clinical Practice Recommendations for gestational diabetic screening and diagnosis _____
Demonstrates knowledge of normal and abnormal of required prenatal screening tests _____
Completes pre-delivery home visit _____
Educates regarding home birth supplies _____

Identifies and takes appropriate action including consultation, referral, or immediate transport when indicated and according to LMW Protocols in the following Prenatal situations:

Suspected abnormality on physical examination _____
Size/Date discrepancy _____
Elevated Blood Pressure Readings _____
Abnormal Kick Count _____
Abnormal weight gain or loss _____
Abnormal Prenatal screening tests _____
Symptoms of urinary tract infections _____
Hyperemesis _____
Abnormal Fetal Heart Rate Patterns _____
Absence of Fetal Heart Rate _____
Position other than vertex presentation _____
Preterm labor _____
Symptoms of Ectopic (Tubal)pregnancy _____
Abnormal vaginal bleeding _____
Prolonged or Premature rupture of membranes _____
Post term pregnancy _____

Labor and Birth

Assessment Skills:

Takes history relevant to labor _____
Assesses effacement and dilation of cervix _____
Assesses station of presenting part _____
Assesses fetal lie, position, and descent _____
Assesses uterine contractions for frequency, duration, and intensity _____
At required intervals, monitors and assesses fetal heart rate during and between contractions _____
Assesses food and fluid intake and output _____

Documentation of Acquisition of Clinical Knowledge and Skills

Assesses maternal well-being and responds appropriately:

Vital signs _____

Emotional well being _____

Assesses labor progress _____

Draft

Intervention Skills:

Demonstrates basic labor support skills and comfort measures _____

Uses maternal position changes to facilitate labor _____

Demonstrates perineal support and hand techniques for delivery _____

Demonstrates proficiency in assisting normal, spontaneous vaginal birth _____

Supports father and other family members _____

Organizes birth equipment _____

Follows sterile technique _____

Identifies and takes appropriate action including consultation, referral or immediate transport when indicated and according to LMW Protocols in the following Intrapartum situations:

Abnormal fetal heart rates/patterns _____

Prolapsed cord _____

Breech presentation and birth _____

Face presentation and birth _____

Multiple birth _____

Shoulder dystocia _____

Abnormal bleeding _____

Nuchal hand, arm, or cord _____

Edematous cervical lip _____

Rupture of membranes _____

Meconium stained fluids _____

Abnormal changes in vital signs (maternal) _____

Maternal dehydration and/or exhaustion _____

Prolonged labor in:

Primagravida _____

Multigravida _____

Abnormal progress of labor _____

Symptoms of Pre-eclampsia _____

Suspected fetal death _____

Postpartum Period

Assessment Skills

Determines signs of placental separation _____

Assesses placenta for size, structure, completeness, cord insertion, and number of vessels, and color _____

Assesses uterus from birth throughout the immediate postpartum period for height, size, consistency, and retained clots _____

Identifies bladder distention and consults or refers if indicated _____

Assesses and estimates blood loss _____

Assesses lochia: amount, odor, consistency, color _____

Recognizes postpartum hemorrhage _____

Recognizes symptoms of shock _____

Assesses perineum and cervix for lacerations _____

Documentation of Acquisition of Clinical Knowledge and Skills

Identifies potential perineal infection or suture breakdown _____
Identifies abnormal uterine size after delivery of placenta _____
Identifies signs of uterine infection _____
Identifies need for Family Planning counseling and refers as indicated _____

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Intervention Skills:

Appropriately assists with placental delivery _____
Demonstrates competency in repair of 1st and 2nd degree perineal lacerations _____
Demonstrates plan for referral for extensive lacerations _____
Takes appropriate action for postpartum hemorrhage (fundal massage, bimanual compression, expression of clots, activating emergency transport plan) _____
Demonstrates correct maternal positioning for treatment of shock and activates emergency transport plan _____
Instructs the mother on postpartum conditions requiring medical evaluation (i.e. excessive bleeding, increasing pain, severe headaches or dizziness or inability to void) _____
Develops guidelines for emergency transport of mother or baby _____
Performs maternal exam at 12-24 hours _____
Performs Postpartum evaluation at 2-6 weeks _____

Identifies and takes appropriate action including consultation, referral or immediate transport when indicated and according to LMW Protocols in the following Postpartum situations:

Abnormal uterine involution _____
Maternal fever _____
Signs of uterine infection _____
Signs of breast infection _____
Hemorrhage _____
Third and fourth degree lacerations _____
Signs and symptoms of shock _____
Activates emergency transport plan _____

Newborn Care

Assessment Skills:

Recognizes signs and symptoms of respiratory distress, possible infection, seizures or jaundice in newborns _____
Determines APGAR scores at one and five minutes _____

Performs newborn assessment and evaluation to minimally include:

General appearance _____
Alertness _____
Flexion of extremities and muscle tone _____
Sucking _____
Palate: visualization and palpation _____
Skin color, lesions, birthmarks, vernix, lanugo, and peeling _____
Measurements of length, head and chest circumference _____
Weight _____
Head: molding, fontanelles, hematoma, caput, sutures _____

Documentation of Acquisition of Clinical Knowledge and Skills

Eyes: jaundice of whites, pupils, tracking, spacing _____
Ears: positioning, responds to sound, appear patent _____
Observe chest for symmetry _____
Listen to and count heart rate and respirations _____
Fingers and toes, normal structure and appearance, creases, prints _____
Genitalia: normal appearance, testicle descent in males _____
Takes and records temperature _____
Takes and records femoral pulse _____
Assesses baby for jaundice _____
Gestational age assessment and refers for less than 36 weeks gestation _____
Performs newborn exam at 24-48 hours _____

Draft

Intervention Skills:

Assures that the baby's airway is clear, uses suction when indicated _____
Promotes temperature regulation of newborn _____
Supports the establishment of emotional bonds among the baby, mother, and family _____
Cuts, clamps, and cares for cord _____
Collects cord blood when indicated _____
Documents administration of eye prophylaxis _____
Performs or refers for the state required Newborn Screening test _____
Completes Infant Hearing Loss Screening Form _____
Educates mother/parents regarding cord care _____
Assists mother in establishing breastfeeding _____
Provides breastfeeding instruction information _____
Instructs mother in normal and abnormal feeding patterns _____
Assists with breastfeeding positioning and milk expression _____

Identifies and takes appropriate action including consultation ,referral or immediate transport when indicated and according to LMW Protocols in the following Newborn situations:

Apgar score of less than 5 at one minute or 7 at 5 minutes _____
Jaundice at 0-24 hours _____
Meconium staining on the skin _____
Abnormal heart rate _____
Birth weight less than 5 lbs or greater than 10 lbs _____
Abnormal voiding or stool pattern _____
Temperature over 100 or less than 97.7 _____
Abnormal cry _____
Abnormal feeding patterns (vomiting, poor suck, lethargy) _____
Jaundice at 24-48 hours _____
Abnormal respiratory pattern (tachypnea or apnea) _____
Signs of bleeding (i.e. petechia, bruises) _____
Rupture of membranes more than 24 hours before birth _____

Education and Counseling Skills

Interaction, Support and Counseling Skills:

Understands and applies principles of informed choice _____

Documentation of Acquisition of Clinical Knowledge and Skills

Exhibits communication skills with women, peers, other health care providers _____

Functions as women's advocate during pregnancy, birth, and postpartum period _____

Assesses maternal support system _____

Consults with other health care professionals regarding problems _____

Basic Prenatal Education

Understands and can demonstrate knowledge of:

Emotional and physical changes during pregnancy and postpartum _____

Signs of labor _____

Fetal development _____

Preparing home and family members for birth, as is culturally relevant _____

Preparation for breastfeeding _____

Effects of smoking, drugs, and alcohol consumption _____

Signs and symptoms that necessitate an immediate call to the midwife _____

Preparation for the postpartum period _____

Exploration of fears, concerns, and psycho-social status with family, as appropriate _____

Benefits of exercise _____

Sexuality education appropriate to pregnancy and postpartum _____

Information about required prenatal tests and lab work _____

Circumcision information, as culturally appropriate _____

Information regarding eye prophylaxis _____

Information regarding vitamin K _____

Information regarding the Lay Midwife Newborn Care Kit provided by the Division _____

Information regarding the state required PKU for newborn screening _____

Information regarding the Newborn Screening test _____

Information regarding Screening for Infant Hearing Loss _____

Draft

Record Keeping and Forms

Demonstrates knowledge on completion of the Birth Certificate _____

Demonstrate knowledge on completion of the Acknowledgement of Paternity

Affidavit _____

Demonstrate knowledge of Licensed Midwife Caseload Log and Division submission requirements _____

Demonstrate knowledge of Complication Report and Division submission requirements _____

Understand components of Emergency Back-up Plans _____

Understand components of Lay Midwife Disclosure Form _____

Understand the Lay Midwife record keeping requirements _____

Understand the Division record audit requirements _____

Understand requirements for CLIA certification to perform laboratory tests _____

Documentation of Acquisition of Clinical Knowledge and Skills

By signing this form for the Documentation of Acquisition of Clinical Knowledge and Skills, I recognize that I have completed the orientation process for each of the skills listed. I have demonstrated knowledge, understanding and competency in the skills and procedures as verified thru demonstration or discussion by my supervising preceptor(s). I have demonstrated knowledge of and adherence to the Rules and Regulations Governing the Practice of Lay Midwifery in Arkansas.

Draft

Signature of Preceptor

date

Signature of Apprentice

date

Notary seal for verification of signatures:

Signature of Notary

date signed

date of expiration

Documentation of Acquisition of Clinical Knowledge and Skills

Draft

Preceptor Verification Form for Licensed Midwife Application

All apprentices must have a Preceptor-Apprentice agreement on file with the Department of Health. This preceptor is responsible for the training of the apprentice and for the majority of the required clinical experiences. Other midwives licensed in the state of Arkansas may sign for some of the clinical experiences and skills. If any preceptor not licensed in the state of Arkansas is also a signer of any clinical experiences or skills, that preceptor must have a Preceptor-Apprentice Agreement on file with the Department. The following information must be filled out for any preceptor who signs any portion of the Application as documentation of clinical experiences or skills. Preceptors must be licensed in a state as an LM or CNM, or must have the credential Certified Professional Midwife. Number of births listed below means the number supervised for THIS APPRENTICE, not the total experience of the supervising midwife. Fill out all lines for documentation of clinical experiences, indicating zero if none supervised, before signing.

Primary Preceptor:

Name _____
Address _____
Phone _____ E-mail _____
Licensed in which state? _____ License number _____
CPM? _____ CPM # _____ date of expiration _____
Dates of supervision _____ to _____
Number of births supervised as assistant _____ number primary _____
Number PRIMARY: initials _____, prenatals _____, newborns _____, postpartums _____
Signature of Preceptor _____

Additional Preceptors whose signatures are on any of the application forms:

Name _____
Address _____
Phone _____ E-mail _____
Licensed in which state? _____ License number _____
CPM? _____ CPM # _____ date of expiration _____
Dates of supervision _____ to _____
Number of births supervised as assistant _____ number primary _____
Number PRIMARY: initials _____, prenatals _____, newborns _____, postpartums _____
Signature of Preceptor _____

Name _____
Address _____
Phone _____ E-mail _____
Licensed in which state? _____ License number _____
CPM? _____ CPM # _____ date of expiration _____
Dates of supervision _____ to _____
Number of births supervised as assistant _____ number primary _____
Number PRIMARY: initials _____, prenatals _____, newborns _____, postpartums _____
Signature of Preceptor _____

Documentation of Acquisition of Clinical Knowledge and Skills

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Additional Preceptors whose signatures are on any of the application forms:

Name _____
Address _____
Phone _____ E-mail _____
Licensed in which state? _____ License number _____
CPM? _____ CPM # _____ date of expiration _____
Dates of supervision _____ to _____
Number of births supervised as assistant _____ number primary _____
Number PRIMARY: initials _____, prenatals _____, newborns _____, postpartums _____
Signature of Preceptor _____

Name _____
Address _____
Phone _____ E-mail _____
Licensed in which state? _____ License number _____
CPM? _____ CPM # _____ date of expiration _____
Dates of supervision _____ to _____
Number of births supervised as assistant _____ number primary _____
Number PRIMARY: initials _____, prenatals _____, newborns _____, postpartums _____
Signature of Preceptor _____

Name _____
Address _____
Phone _____ E-mail _____
Licensed in which state? _____ License number _____
CPM? _____ CPM # _____ date of expiration _____
Dates of supervision _____ to _____
Number of births supervised as assistant _____ number primary _____
Number PRIMARY: initials _____, prenatals _____, newborns _____, postpartums _____
Signature of Preceptor _____

Name _____
Address _____
Phone _____ E-mail _____
Licensed in which state? _____ License number _____
CPM? _____ CPM # _____ date of expiration _____
Dates of supervision _____ to _____
Number of births supervised as assistant _____ number primary _____
Number PRIMARY: initials _____, prenatals _____, newborns _____, postpartums _____
Signature of Preceptor _____

Instructions for Completing Midwife Caseload and Birth Log And Complications Reports

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Refer to Section 700 of the Regulations Governing the Practice of Lay Midwifery in Arkansas 2007. Midwife Caseload and Birth Log, and Complications Report forms are provided by the Department.

The Caseload and Birth Log is designed to be a perpetual report, so that the same form may be copied and re-submitted on a monthly basis until the page is full and a new page is started (each page allows for listing 17 clients). Accurate spelling of the client's name is required. Mail a copy of the Log to the Department postmarked no later than the 10th of each month. It is not necessary to mail a copy of the Log for a month that has none of the reportable events listed below.

Use the Caseload and Birth Log to report the following:

1. Women who receive prenatal care from the lay midwife for more than one month of the gestation period regardless of whether or not the lay midwife attended the birth.
 - a. You may enter the name and estimated due date on the Log at any point a client receives more than one month of care.
 - b. The Division requests all clients receiving care be listed on the Log by 36 weeks gestation in order to establish statistically reliable data for annual reports.
2. Clients who are referred for care, transported, lost to follow-up (or leave midwife care), or for other reasons are not attended by the midwife at birth.
3. Consultations between the lay midwife and a physician or CNM to discuss the status and future care of the client.
4. Labors/births attended by the midwife.
5. Apprentice name when apprentice participates in the client's care.

Use the Complications Report form to document complications and submit to the Division by the 10th of the month for the following:

1. Consultations (consults). Refer to Rules and Regs (definition 204): occurs between the licensed lay midwife and a physician or CNM discussing the status and future care of the client and may result in a Referral (definition 214) in which the client receives an office visit for evaluation and determination of future care. A consult for a complication must be documented whether or not a Referral, Transfer or Transport becomes necessary (Item 700). Consultation and/or Referral is required for:
 - a) Pre-existing conditions listed in the Rules and Regs Item 406.01
 - b) Prenatal conditions listed in 406.02
 - c) Intrapartum conditions listed in 407.02
 - d) Postpartum conditions listed in 408.02
 - e) Newborn conditions listed in 409.02
 - f) Other problems not specified in the protocol in which there are significant deviations from normal (noted in 406 and 600)

Instructions for Completing Midwife Caseload and Birth Log And Complications Reports

2. Transfers. Refer to Rules and Regs (definition 216): occurs when complications arise beyond the scope of midwife practice defined in the regulations. A transfer may result from a consultation and/or referral for a complication, or may occur for social reasons (relocation, preference for another provider, preference for a hospital birth, financial reasons, et al). The delivery date for transfers is recorded when known by the midwife. Transfers resulting from complications include:
 - a) Conditions that preclude midwife care (406.01, 407.01, 408.01, 409.01)
 - b) Recommendation of the consultant (physician, CNM, Department clinician) following a risk assessment, consultation or referral
 - c) Other conditions as determined by the midwife
3. Transports. Refer to Rules and Regs (definitions 206 and 207): occurs when treatment or evaluation is necessary for an emergency condition or complication for mother or babe, and includes:
 - a) Antepartum Conditions (406.01, 406.02)
 - b) Intrapartum conditions (407.01, 407.02)
 - c) Postpartum conditions (408.01, 408.02)
 - d) Newborn conditions (409.01, 409.02)
 - e) Other conditions as determined by the midwife
4. Perinatal Death. Refer to Rules and Regs 700: complications resulting in the death of a mother, infant, or fetus within 24 hours of delivery must be reported to the Department within 2 working days. The client information should appear on the Caseload for the month but the Perinatal Death Report does not need to be re-submitted.

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Name of Apprentice_____

Year _____ Report Dates _____

[illegible]

A copy of the Caseload and Birth Log is submitted monthly (unless no changes or events), listing all clients by 36 weeks, and postmarked by the 10th of the following month. Consults/Referrals, Transfers and Transports (highlighted columns) must be documented on the Complications Reporting form in the month they occur and submitted with the Caseload and Birth Log. Complications that result in death of mother, infant or fetus must be reported to the department within two working days. Submit the Caseload and Birth Log and attachments by the 10th of the following month to: **Arkansas Department of Health, Women's Health, 5800 West 10th Street, Suite 401, Little Rock, AR 72204.**

Complications Report

Arkansas Department of Health
Licensed Lay Midwife

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Midwife Name:

Apprentice Name:

Date of Report:

Client Name:

EDD:

Midwife Action: Consultation_____ Referral_____ Transfer_____ Transport_____

Condition Identified and Related History:

Consultants Name (Physician, CNM, or ADH Clinician):

Address

Telephone Number

Date of Consultation, Appointment, Transfer or Transport:

Findings of Consultant:

Recommendations and Actions of Consultant:

Midwife Plan of Care:

Outcome of Care:

In accordance with regulation 700 of the Regulations Governing the Practice of Lay Midwifery in Arkansas 2007 the Complications Report must be mailed to the Department by the 10th of the month following the event. Enclose the report with the corresponding Caseload and Birth Log for the month. Documentation of medical consults should be maintained in the client health record and made available upon request.