NMDOH MATERNAL HEALTH PROGRAM
Attn: License application
P.O. Box 25307
Albuquerque, NM 87125
Account XXXXXX7789

Phone (505) 476-8907
or (505) 476-8866
Email<amber.montoya@state.nm.us>
or <catherine.avery@state.nm.us>

NEW MEXICO DEPARTMENT OF HEALTH
DIRECT-ENTRY MIDWIFE LICENSE RENEWAL APPLICATION

INSTRUCTIONS:

✓In the grid on the page 2, list the minimum 30 contact hours of midwifery continuing education as defined in Sections 7.5 and 7.6 of the LM regulations that you have obtained in the last 2 years. Include the continuing education certificates with this renewal application.

✓Mail the application and enclosures to the exact address in the above heading box.

✓Be sure to enclose the following with your renewal application:

1. HSC release form
2. HSC query information form (they are the last two pages of the application)

✓Include photocopies showing current (within two years) certification in CPR, neonatal resuscitation and IV therapy. Your name, the instructor's signature and date of expiration must be visible. These certifications cannot be counted towards your continuing education hours.

✓ Enclose proof of peer review participation within the last four years. Send with each license renewal.

✓Enclose any quarterly reports or summary quarterly reports of midwifery care you have given in New Mexico during the past 2 years that you have not submitted to the Program previously.

- If you have been using the MANA website for client data entry, you may download an annual report of your client data and submit that in place of the Quarterly Report form.
- If you are submitting Quarterly Report forms, for each quarter you were attending deliveries in New Mexico you must submit a summary quarterly report.
- If you gave no midwifery care during any quarter or did not attend at NM births, indicate that on the summary quarterly report form. (You can use a single form to show no care given for more than one quarter.)

✓ ***Fees:* Enclose $50.00 check or money order made out to Public Health Division.** Please write *Midwifery Licensure* on the check memo line.

Full Name ____________________

Date of Birth ____________________ SSN ____________________

Address ____________________

City ____________________ State ____________________ Zip Code __________

Home Phone ____________________ Work Phone ____________________

Email Address ____________________

List states/countries you been licensed as a health care provider ____________________

____

1. Have you EVER been named in a legal suit alleging misconduct, malpractice or negligence as a RN, CNM, or other licensed health care provider? Yes ☐ No ☐
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 updated information.)

2. 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?
Yes ☐ No ☐
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 updated information.)

The National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank will 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.

Date	Title of Activity	Sponsor	Hours
		TOTAL	

Midwifery education institution or preceptor____

Date of graduation____

City/State____

County____

Professional degree(s)____

Specialty (ies)____

Current practice name(s) and complete business address (es)_________________________________

____

NMDOH Licensed 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: ______________________

A. 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 Languages: ____

B. 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 or country. Specify: __________________________

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

C. CURRENT ACTIVITIES

-- On average, how many hours per week do you practice in NM?

(in direct patient care)______ (on call)______

-- On average, how many weeks per year do you practice in NM? (check one)

(52 weeks – year-round) ___

(<26 weeks/year – part time in state) _____

-- 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%

________% Attend Births

________% Well Women's Health

________% Research

________% Other. Please specify:____

Do you teach or precept midwifery students in your practice (Y/N)? _____________

How many students did you precept in the past 12 month period? ______________

D. PRACTICE CHARACTERISTICS

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

☐Solo, Independent Practice

☐Group of Same Specialty. Specify total number of group members excluding self:__________

☐Multi-Specialty, Group Practice. Specify total number of other specialists: _______________

E. PRACTICE DIFFICULTIES

-- Does your practice encounter any claim reimbursement issues for services rendered to patients?
☐No ☐Yes Please explain (cont'd on next page):

____

____

____

____

-- Please mark the services with which you currently experience difficulty in referring patients since your last licensure application. Mark all that apply

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

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

____

____

____

____

F. PRACTICE PLAN OR CHANGE

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

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

☐Significantly reduce patient care hours ☐Move your practice out of New Mexico

☐None of the above

-- If you are retiring, moving, or reducing patient care hours in the next 2 years (24 months), what factors led to that decision? Please mark 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 or feedback that you would like to share with the Maternal Health Program?

____

____

____

____

HSC

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

LA Credentials

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: _____

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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.