Florida Department of Health
Council of Licensed Midwifery
Application for Temporary Midwifery Certificate in Areas of Critical Need

Mail competed application and fee to:

Department of Health
Council of Licensed Midwifery
Post Office Box 6330
Tallahassee, Florida 32314-6330

Fee: $50.00- All fees must be made payable to the Department of Health and must be a cashier's check or money order.

Please be advised that this form must be accompanied by an application for licensure by endorsement and documentation of the area of critical need pursuant to Section 467.0125(2)(a), F.S.

Applicant's Information:

Last Name First MI

Home Phone Business Phone

E-Mail Address

Street Address Apt.#

Midwifery School

Date Graduated Type of Degree Awarded

City State Zip

Supervisor's Information:

Last Name First MI

Home Phone Business Phone

E-Mail Address

Street Address Apt.#

Profession: (DO, MD, CNM, LM)

County of Practice

City State Zip

Signature of Applicant:

I have carefully read the questions in the foregoing application and have answered them completely and without reservations of any kind.

Signature

Date