This form should be submitted to:
Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, FL 32399-3275

Autonomous Certified Nurse Midwife Adverse Medical Incident Report

1. OFFICE INFORMATION

Office Name: ______________________________

Address: ______________________________
Street City State ZIP

County: ____________ Certified Nurse Midwife Name: ____________

Name of Licensee Reporting: ____________
(if applicable)

2. PATIENT INFORMATION

Patient Identification #: ____________

Patient Name: ____________ Date of Birth: ____________ Gender: ________
MM/DD/YYYY

Address: ______________________________
Street City State ZIP

Date of Visit: ____________ Purpose of Visit: ____________
MM/DD/YYYY

Diagnosis: ______________________________

3. INCIDENT INFORMATION

Location of Incident: ______________________________

Incident Date: ____________ Incident Time: ________ AM PM
MM/DD/YYYY

A. Describe circumstances of the incident (use additional sheets if necessary).

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B. Describe the action taken.

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Referred to Physician Transported to Hospital

4. SIGNATURE

Signature: ______________________________ License #: ____________
Certified Nurse Midwife/Licensee Submitting Report

Date Report Completed: ____________ Time Report Completed: ________ AM PM
MM/DD/YYYY