Meeting Minutes
SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
Teleconference
March 12, 2018 9:00 a.m. Central

President Debbie Pease called the meeting to order at 9:00 am. The roll was called. A quorum was present.

Members of the board in attendance via phone: Autumn Cavender-Wilson, Kimberlee McKay, MD, Susan Rooks, Debbie Pease, and Pat Schwaiger.

Others in attendance via phone: Ashley Tanner, DOH; Susan Sporrer, DOH

Pease requested that New Business be moved to precede Old Business on the agenda. Rooks moved approval of the agenda as amended; seconded by Cavender-Wilson. The board voted by roll call. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED.**

There were no members of the public in attendance on the call so no open forum was necessary.

Schwaiger moved to approve the January 29, 2018 minutes; seconded by Rooks. The board voted by roll call. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED**

Cavender-Wilson moved to approve the financial report as of March 3, 2018; seconded by Rooks. The board voted by roll call. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED**

The Board discussed revisions to the mission statement. The current statement read " This Mission of the South Dakota Board of Certified Professional Midwives is to ensure the health, welfare and safety of clients seeking out-of-hospital midwifery care via licensure of qualified practitioners, enforcement of updated statutes and rules, and expeditious and fair processing of complaints against licensees." It was changed to read "The mission of the South Dakota Board of Certified Professional Midwives is to secure safe, out-of-hospital childbirth attended by licensed and competent midwives, to protect the consumer of midwifery services by holding these midwives accountable to the statutes and rules pertaining to their profession, to update rules as needed to meet current, evidence-based standards of midwifery practice, to license qualified midwives, and to process complaints in a fair and expeditious manner." Schwaiger moved approval of the new mission statement; seconded by Rooks. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED**

The board reviewed the initial application form. Sections 8, 9, and 11 were removed and sections were added for date of CPM registration and CPM registration number from NARM and bridge certificate number from NARM. On the last page, remove language reading "an accrediting organization approved by the Board" and insert "Midwifery Education and Accrediting Council". Ashley Tanner will create a renewal application form for review at the next meeting.

Pease said that there was one proposal submitted in response to the RFP issued by the Board but the cost was more than the board can afford so the RFP review committee recommended reissuing the RFP. Cavender-Wilson moved to reissue the RFP; seconded by McKay. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED**

- Rooks moved to approve the form; seconded by McKay. The board voted by roll call. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED**
- Maternal Transfer – Line will be added to collect emergency contact information. The form will be finalized at the next meeting.
- Birth Reporting – Cavender-Wilson moved to approve the form; seconded by Schwaiger. The board voted by roll call. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED**
- Informed Consent – Pease with work with the DOH to combine comments received by Pease and Cavender-Wilson into a revised informed consent form for approval at the next meeting.

The board reviewed the Midwife/Student Preceptor form. The board asked that two separate areas on the form be created to collect name, e-mail, address, and phone for the preceptor and the student as well as a box to collect the preceptor's SD license number. Rooks moved approval of the form as amended; seconded by Schwaiger. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED**

Rooks moved approval of the maternal transport form; seconded by Schwaiger. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED**

The board reviewed the informed consent form. The first disclosure statement was amended to add "advanced practice nursing" so will now read "I understand that the Certified Professional Midwife is not licensed to practice medicine or advanced practice nursing, and that I am not seeking a licensed practitioner of medicine or advanced practice nursing such as a physician or certified nurse midwife, as the primary caregiver for my pregnancy." Cavender-Wilson moved approval of the form as amended; McKay seconded. Cavender-Wilson, McKay, Pease, Rooks, and Schwaiger voted aye. **MOTION PASSED**

The board reviewed the draft rules related to definitions, scope and practice standards, required physician consultation, recommended physician consultation and maternal and infant transfer. Changes will be incorporated into the next version of the draft. Board members will receive a revised draft for review. If there are not substantial areas of concern, that draft will be shared with interested parties prior to the next board meeting. Comments on the draft will be reviewed at the next board meeting prior to initiation of the formal rules adoption process.

The next board meeting will be determined once the Interim Rules Review Committee had set their schedule for the coming year.

Cavender-Wilson made a motion to adjourn, seconded by McKay. Cavender-Wilson, Pease and McKay voted aye; Rooks and Schwaiger absent. **MOTION PASSED.** The meeting adjourned at 11:47 a.m.

Respectfully Submitted,
Autumn Cavender-Wilson, Secretary

Remaining Authority by Object/Subobject

Expenditures current through 04/28/2018 09:23:22 AM
HEALTH -- Summary
FY 2018 Version -- AS -- Budgeted and Informational
FY Remaining: 17.5 %

09213 Board of Certified Prof Midwives - Info

Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
EMPLOYEE SALARIES							
5101030	Board & Comm Mbrs Fees	0	1,440	0	0	-1,440	0.0
Subtotal		**0**	**1,440**	**0**	**0**	**-1,440**	0.0
EMPLOYEE BENEFITS							
5102010	Oasi-employer's Share	0	110	0	0	-110	0.0
Subtotal		**0**	**110**	**0**	**0**	**-110**	0.0
51 Personal Services							
Subtotal		**0**	**1,550**	**0**	**0**	**-1,550**	0.0
TRAVEL							
5203030	Auto-priv (in-st.) H/rte	650	205	0	0	445	68.5
5203040	Air-state Owned-in State	0	3,927	0	0	-3,927	0.0
5203100	Lodging/in-state	200	353	0	0	-153	0.0
5203140	Meals/taxable/in-state	100	0	0	0	100	100.0
5203150	Non-taxable Meals/in-st	0	110	0	0	-110	0.0
5203260	Air-comm-out-of-state	0	1,168	0	0	-1,168	0.0
5203320	Incidentals-out-of-state	0	151	0	0	-151	0.0
5203350	Non-taxable Meals/out-st	0	56	0	0	-56	0.0
Subtotal		**950**	**5,970**	**0**	**0**	**-5,020**	0.0
CONTRACTUAL SERVICES							
5204020	Dues & Membership Fees	600	0	0	0	600	100.0
5204080	Legal Consultant	3,000	0	0	0	3,000	100.0
5204090	Management Consultant	10,500	0	0	0	10,500	100.0
5204180	Computer Services-state	28	0	0	0	28	100.0
5204190	Computer Services-private	500	0	0	0	500	100.0
5204200	Central Services	812	104	0	0	708	87.2
5204204	Central Services	150	0	0	0	150	100.0
5204207	Central Services	130	468	0	0	-338	0.0
5204360	Advertising-newspaper	1,690	0	0	0	1,690	100.0
5204460	Equipment Rental	0	25	0	0	-25	0.0
5204510	Rents-other	0	95	0	0	-95	0.0
5204590	Ins Premiums & Surety Bds	700	815	0	0	-115	0.0
5204960	Other Contractual Service	260	0	0	0	260	100.0
Subtotal		**18,370**	**1,507**	**0**	**0**	**16,863**	91.8
SUPPLIES & MATERIALS							

Remaining Authority by Object/Subobject

Expenditures current through 04/28/2018 09:23:22 AM

HEALTH -- Summary

FY 2018 Version -- AS -- Budgeted and Informational

FY Remaining: 17.5 %

09213 Board of Certified Prof Midwives - Info

Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
5205020	Office Supplies	50	0	0	0	50	100.0
5205320	Printing-commercial	50	0	0	0	50	100.0
5205350	Postage	100	0	0	0	100	100.0
5205390	Food Stuffs	0	154	0	0	-154	0.0
Subtotal		**200**	**154**	**0**	**0**	**46**	23.0
	CAPITAL OUTLAY						
5207900	Computer Hardware	480	0	0	0	480	100.0
Subtotal		**480**	**0**	**0**	**0**	**480**	100.0
52 Operating Subtotal		**20,000**	**7,631**	**0**	**0**	**12,369**	61.8
Total		**20,000**	**9,181**	**0**	**0**	**10,819**	54.1

Code of Conduct and Conflict of Interest Policy for Use By State Authority, Board, Commission, and Committee Members

Purpose

The purpose of this code of conduct and conflict of interest policy ("Code") is to establish a set of ethical principles and guidelines for members of state authorities, boards, commissions, or committees when acting within their official public service capacity. This Code applies to all appointed and elected members of state authorities, boards, commissions, and committees (hereinafter "Boards" and "Board member(s)").

Conflict of Interest for Board Members

Board members may be subject to statutory restrictions specific to their Boards found in state and federal laws, rules and regulations. Those restrictions are beyond the scope of this Code. Board members should contact their appointing authority or the attorney for the Board for information regarding restrictions specific to their Board.

General Restrictions on Participation in Board Actions

A conflict of interest exists when a Board member has an interest in a matter that is different from the interest of members of the general public. Examples of circumstances which may create a conflict of interest include a personal or pecuniary interest in the matter or an existing or potential employment relationship with a party involved in the proceeding.

Whether or not a conflict of interest requires a Board member to abstain from participation in an official action of the Board depends upon the type of action involved. A Board's official actions are either quasi-judicial or quasi-legislative. A quasi-judicial official action is particular and immediate in effect, such as a review of an application for a license or permit. In order to participate in a quasi-judicial official action of the Board, a Board member must be disinterested and free from actual bias or an unacceptable risk of actual bias. A Board member must abstain from participation in the discussion and vote on a quasi-judicial official action of the Board if a reasonably-minded person could conclude that there is an unacceptable risk that the Board member has prejudged the matter or that the Board member's interest or relationship creates a potential to influence the member's impartiality.

A quasi-legislative official action, also referred to as a regulatory action, is general and future in effect. An example is rule-making. If the official action involved is quasi-legislative in nature, the Board member is not required to abstain from participation in the discussion and vote on the action

unless it is clear that the member has an unalterably closed mind on matters critical to the disposition of the action.

"Official action" means a decision, recommendation, approval, disapproval or other action which involves discretionary authority. A Board member who violates any of these restrictions may be subject to removal from the Board to which the member is appointed.

Contract Restrictions

There are federal and state laws, rules and regulations that address conflict of interest for elected and appointed Board members in the area of contracts. As an initial matter, a Board member may not solicit or accept any gift, favor, reward, or promise of reward, including any promise of future employment, in exchange for recommending, influencing or attempting to influence the award of or the terms of a state contract. This prohibition is absolute and cannot be waived.

Members of certain Boards are required to comply with additional conflict of interest provisions found in SDCL Chapter 3-23 and are required to make an annual disclosure of any contract in which they have or may have an interest or from which they derive a direct benefit. The restrictions apply for one year following the end of the Board member's term. The Boards impacted by these laws are enumerated within SDCL 3-23-10. For more information on these provisions, see the State Authorities/Boards/Commissions page in the Legal Resources section of the Attorney General's website at: http://atg.sd.gov/legal/opengovernment/authorityboardcommission.aspx.

Absent a waiver, certain Board members are further prohibited from deriving a direct benefit from a contract with an outside entity if the Board member had substantial involvement in recommending, awarding, or administering the contract or if the Board member supervised another state officer or employee who approved, awarded or administered the contract. With the exception of employment contracts, the foregoing prohibition applies for one year following the end of the Board member's term. However, the foregoing prohibition does not apply to Board members who serve without compensation or who are only paid a per diem. See SDCL 5-18A-17 to 5-18A-17.6. For more information on these restrictions see the Conflict of Interest Waiver Instructions and Form on the South Dakota Bureau of Human Resources website at: http://bhr.sd.gov/forms/.

Other federal and state laws, rules and regulations may apply to specific Boards. For general questions regarding the applicability of SDCL Chapter 3-23 or other laws, a Board member may contact the attorney for the Board. However, because the attorney for the Board does not represent the Board member in his or her individual capacity, a Board member should contact a private attorney if the member has questions as to how the conflict of interest laws apply to the Board member's own interests and contracts.

Consequences of Violations of Conflict of Interest Laws

A contract entered into in violation of conflict of interest laws is voidable and any benefit received by the Board member is subject to disgorgement. In addition, a Board member who violates conflict of interest laws may be removed from the Board and may be subject to criminal prosecution. For example, a Board member may be prosecuted for theft if the member knowingly

uses funds or property entrusted to the member in violation of public trust and the use resulted in a direct financial benefit to the member. See SDCL 3-16-7, 5-18A-17.4, and 22-30-46.

Retaliation for Reporting

A Board cannot dismiss, suspend, demote, decrease the compensation of, or take any other retaliatory action against an employee because the employee reports, in good faith, a violation or suspected violation of a law or rule, an abuse of funds or abuse of authority, a substantial and specific danger to public health or safety, or a direct criminal conflict of interest, unless the report is specifically prohibited by law. SDCL 3-16-9 & 3-16-10.

Board members will not engage in retaliatory treatment of an individual because the individual reports harassment, opposes discrimination, participates in the complaint process, or provides information related to a complaint. See SDCL 20-13-26.

Anti-Harassment/Discrimination Policy

While acting within their official capacity, Board members will not engage in harassment or discriminatory or offensive behavior based on race, color, creed, religion, national origin, sex, pregnancy, age, ancestry, genetic information, disability or any other legally protected status or characteristic.

Harassment includes conduct that creates a hostile work environment for an employee or another Board member. This prohibition against harassment and discrimination also encompasses sexual harassment. Sexual harassment includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexually harassing nature, when: (1) submission to or rejection of the harassment is made either explicitly or implicitly the basis of or a condition of employment, appointment, or a favorable or unfavorable action by the Board member; or (2) the harassment has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Harassment or discriminatory or offensive behavior may take different forms and may be verbal, nonverbal, or physical in nature. To aid Board members in identifying inappropriate conduct, the following examples of harassment or discriminatory or offensive behavior are provided:

- Unwelcome physical contact such as kissing, fondling, hugging, or touching;
- Demands for sexual favors; sexual innuendoes, suggestive comments, jokes of a sexual nature, sexist put-downs, or sexual remarks about a person's body; sexual propositions, or persistent unwanted courting;
- Swearing, offensive gestures, or graphic language made because of a person's race, color, religion, national origin, sex, age or disability;
- Slurs, jokes, or derogatory remarks, email, or other communications relating to race, color, religion, national origin, sex, age, or disability; or
- Calendars, posters, pictures, drawings, displays, cartoons, images, lists, e-mails, or computer activity that reflects disparagingly upon race, color, religion, national origin, sex, age or disability.

The above cited examples are not intended to be all-inclusive.

A Board member who is in violation of this policy may be subject to removal from the Board.

Confidential Information

Except as otherwise required by law, Board members shall not disclose confidential information acquired during the course of their official duties. In addition, members are prohibited from the use of confidential information for personal gain.

Reporting of Violations

Any violation of this Code should be reported to the appointing authority for the Board member who is alleged to have violated the Code.

STATE OF SOUTH DAKOTA
BOARD OF CERTIFIED PROFESSIONAL MIDWIVES

APPLICATION FOR SOUTH DAKOTA CERTIFIED PROFESSIONAL MIDWIFE LICENSE

Instructions: Please READ All accompanying instructions and preparation checklist prior to completing this application. ALL questions contained in this application MUST be answered and ALL supporting documentation MUST be submitted along with this application. Please type or print neatly. If the space provided in this application is not adequate, attach additional sheets of paper for your responses.

1. Name Last	**First**		**Middle**
2. Other name or aliases you have used (include maiden name)			
3. Public Mailing Address: (Address of Record – Include Apt. #, City, State, Zip Code)			
4. Telephone Numbers	**Home** ( )	**Work** ( )	**Cell (if available)** ( )
5. Social Security Number _____ - _____ - _____	**6. Sex:** ☐ **Female** ☐ **Male**	**7. Date of Birth: (Month/Date/Year)**	

8. If you have completed a MEAC approved midwifery education program, list the name and address of the program and provide official transcripts and an official copy of your diploma or certificate. Official copies of diplomas must bear the school seal and the Dean or Registrar's signature. Transcripts must be sent by the institution that conferred the document/certificate.

Name	ADDRESS	DATES OF ATTENDANCE (From: - To:)

9. NARM Registration Number & Date of Certification: #_____ Date:_____

If non-MEAC school graduate, please provide a copy of your Bridge Certificate from NARM.

10. Have you ever been licensed to practice midwifery or any other healing art in another state/country? If yes, list state/country issuing authority, license number, date issued and date of expiration in each issuing agency's jurisdiction. Submit a letter of Good Standing (LGS) from each state in which you are or have held a license. ☐ YES ☐ NO

11. State or Country	**License Number**	**Date of Issuance**	**Date of Expiration**

DISCIPLINARY INFORMATION

If "YES" is answered to any of the below questions please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion / compliance with court requirements.

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense, other than minor traffic violations, that have not previously been reported to the board?	☐ YES ☐ NO
2.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	☐ YES ☐ NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	☐ YES ☐ NO
4.	Has any CPM license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	☐ YES ☐ NO
5.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	☐ YES ☐ NO
6.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance since your last renewal?	☐ YES ☐ NO

7.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	☐ YES ☐ NO
8.	Do you currently owe child support arrearages in the amount of $1000 or more?	☐ YES ☐ NO

PHOTO AREA
(Not to exceed 2"x 3")
(within 12 months)
PHOTO MUST BE OF YOUR HEAD AND SHOULDER AREA ONLY

PROOF/NEGATIVE/DIGITAL, SCANNED, ALTERED, OR POLAROID PHOTOS ARE NOT ACCEPTABLE.

PHOTO DECLARATION

I HEREBY DECLARE AND VERIFY, UNDER PENALTY OF PERGURY, UNDER THE LAWS OF THE STATE OF SOUTH DAKOTA, THAT THE PHOTO OF MYSELF ATTACHED HERETO, WAS TAKEN ON OR ABOUT _____.

_____
Applicant Signature

APPLICANT DECLARATION, SIGNATURE, & NOTARY

State of _____

County of _____

The applicant, _____, being first duly sworn upon his/her oath, disposes and says, that I am the person herein named and subscribing to this application; that I have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; were not procured with fraud or misrepresentation or any mistake of which h the applicant is aware. Further, I hereby authorize all institutions or organizations, my references, and all government agencies (local, state, federal, or foreign) to release to the South Dakota Board of Certified Professional Midwives or its successors any information, files, or records required by the Board in connection with this application; or my ability to safely engage in the practice of certified professional midwifery. I further authorize the South Dakota Board of Certified Professional Midwives or its successors to release to the organization, individuals, or groups listed above any information which is material to this application or any subsequent licensure. I FURTHER UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE, IF ISSUED.

Signature of Applicant _____

Subscribed and sworn before me on this _____ day of _____, 20_____, by_____, personally known to me or proved to on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL
HERE

_____
SIGNATURE OF NOTARY PUBLIC

STATE OF SOUTH DAKOTA
BOARD OF CERTIFIED PROFESSIONAL MIDWIVES

CERTIFICATE OF MIDWIFERY EDUCATION

The undersigned certifies under penalty of perjury that the records of this institution show that

_____,
FULL NAME OF APPLICANT

_____ / _____ / _____, _____,
Social Security Number DATE OF BIRTH – MM/DD/YYYY

successfully completed a midwifery education program accredited by MEAC, and that the applicant was granted the midwifery diploma or certificate at the below mentioned midwifery school on the _____ day of _____, _____.
MONTH YEAR

_____
NAME OF THE MIDWIFERY SCHOOL

_____
FULL ADDRESS

MIDWIFERY SCHOOL SEAL MUST BE IMPRINTED BELOW	ATTENTION MIDWIFERY SCHOOL: The person who signs this form MAY NOT be related to the applicant. Only the president, dean, or registrar may sign the form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months. By _____ PRESIDENT, DEAN, OR REGISTRAR Signed and the school seal affixed this _____ day of _____, _____. MONTH YEAR

South Dakota Board of Certified Professional Midwifery
[Address]
[Phone] ♦ [Fax] ♦ [Website]

Application for Certified Professional Midwife License Renewal

Licensure renewal information and fees must be received by the South Dakota Board of Certified Professional Midwives office *by your license expiration date* or your license will lapse. **It is illegal to practice professional midwifery in South Dakota without an active CPM license.** You are responsible to maintain licensure whether or not you receive a renewal notice.

All forms and fees must be postmarked on or before your expiration date to avoid lapsing.

Please follow instructions carefully to avoid delays in processing your renewal. If any information is incorrect, incomplete or illegible, processing may be delayed. Upon receipt of all forms and fees at the South Dakota Board of Certified Professional Midwives office your application will be considered for renewal. You will be notified if additional information is required.

To RENEW your CPM license, **submit the following** to the South Dakota Board of Certified Professional Midwives office:

- Completed *Application for CPM License Renewal Form*
- Completed *Verification of Experience Form*
- **Fee: $1500**
  - Payment should be in the form of a money order or personal check payable to South Dakota Board of Certified Professional Midwives. Fees are non-refundable and must accompany form. A $40 fee will be charged for any insufficient check written.

South Dakota Board of Certified Professional Midwives
[Address]
[Phone] ♦ [Fax] ♦ [website]

Application to Renew CPM License

I request to RENEW:

- SD CPM License Number: _____

Name (Last): _____(First):_____(Middle):_____

Address: _____

City: _____State:_____Zip:_____

Telephone (Home): _____(Work):_____(Cell):_____

Date of Birth: _____/_____/_____ Email Address:_____

Disciplinary Information

If "YES" is answered to any of the below questions please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion / compliance with court requirements.

Please report all instances not previously reported to the board. Have you ever:

1.	Committed fraud, deceit, or misrepresentation in procuring or attempting to procure a license?	❑ Yes	❑ No
2.	Aided or abetted an unlicensed person to practice as a certified professional midwife?	❑ Yes	❑ No
3.	Engaged in practice as a certified professional midwife under a false or assumed name and failed to register that name pursuant to chapter 37-11 or impersonated a license holder of a like or different name.	❑ Yes	❑ No
4.	Committed an alcohol or drug related act or offense that interferes with the ability to practice midwifery safely?	❑ Yes	❑ No
5.	Negligently, willfully, or intentionally acted in a manner inconsistent with the health and safety of those entrusted to your care as a certified professional midwife?	❑ Yes	❑ No
6.	Had the authorization to practice as a certified professional midwife denied, revoked, or suspended or had other disciplinary action taken in another state?	❑ Yes	❑ No
7.	Violated any provision of Chapter 36-9C or rule pursuant to 36-9C?	❑ Yes	❑ No
8.	Been convicted of a misdemeanor and/or felony?	❑ Yes	❑ No
9.	Engaged in substandard, unprofessional, or dishonorable conduct?	❑ Yes	❑ No

Employment and Education Information:

If you have attained an additional level of education (certifications, degrees) in the last 2 years, please specify:

_____

If you plan to pursue additional education in the next 2 years, please specify:

_____

Are you currently working as a Certified Professional Midwife? ☐ Yes ☐ No

If yes: What is the average number of births you have done per month in the **last** 12 months? _____

What is the number of births you would like to average per month in the **next** 12 months? _____

If no, are you:

- ❑ Retired
- ❑ Seeking Work as a CPM
- ❑ Inactive
- ❑ Volunteer Only

If other than self-employed, please list name and address of employer(s):

_____

Actively employed in a field other than professional midwifery (select one)

- ❑ No
- ❑ Yes, Full-time
- ❑ Yes, Part-time
- ❑ Yes, Per diem

Do you intend to leave / retire from CPM practice in the next 5 years? ☐ Yes ☐ No

Other states in which you have ever held a license:

Active License: _____

Inactive License: _____

List all states where **currently practicing** professional midwifery:

_____

Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure renewal in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant _____ **Date** _____

South Dakota Board of Certified Professional Midwives
[Address]
[Phone] ♦ [Fax] ♦ [Website]

Inactive Status: Should you wish to place your CPM license on inactive status, submit completed written request below along with fee ($100) to the South Dakota Board of Certified Professional Midwives office before your certified professional midwife license expires.

I request to INACTIVATE:

- o SD CPM License Number: _____

Name (First): _____ (Middle): _____ (Last): _____

Address: _____
Street/PO Box City State Zip

Telephone: Home: (___) _____ Other: (___) _____ Email: _____

Fee required to inactivate **each** South Dakota license requested is **$100.**

You are required to pay this fee once upon initial inactivation.

Payment should be in the form of a personal check or money order payable to South Dakota Board of Certified Professional Midwives. Fees are non-refundable and must accompany form. A $40 fee will be charged for any insufficient check written.

Sign, date and return this form with fee.

Signature of Applicant _____ **Date** _____

Verification of Experience

Return completed form with your renewal application to the South Dakota Board of Certified Professional Midwives.

To obtain/retain active licensure, a CPM must provide verification of a minimum of 140 hours in a 12-month period OR 480 hours in six years of experience in professional midwifery.

In the last: □ 12 months or □ 6 years (please specify)

_____ Hours at prenatal appointments

_____ Hours at births

_____ Hours at postpartum visits

_____ Hours spent teaching midwifery

_____ Other CPM related activity (specify) _____

_____ Total

Please Print

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure renewal in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant _____ **Date** _____

The board may request a review of your records to verify the hours specified on this form.

South Dakota Board of Certified Professional Midwives

[Address]
[City, State, Zip]
[Phone]

Please complete the following information and submit copies of pertinent documents, including medical records if available; do not submit your original documents. State in detail all facts you believe justify your complaint. If possible, state whether information is within your personal knowledge, and if not, provide the source(s).

Please send this completed, signed form to the South Dakota Board of Certified Professional Midwives, attention: Complaints. If necessary, we may contact you for additional information, and you will be notified of the final decision. Please be aware that evaluation and investigation of a complaint is a time consuming process.

Name of Complainant: _____

Address: _____

Phone:_____ Email:_____

Additional Complaint(s), if any: _____

Individual(s) against whom this complaint is issued: _____
CPM License # if known: _____

Place of Employment: _____

Complaint and Additional Information

- Were you the patient/individual for whom care was provided? ☐ Yes ☐ No
  If not, for whom was care provided (name and relationship to you)?
  _____
- Do you represent the employer of the CPM involved? ☐ Yes ☐ No
  If so, the name and contact information for the facility:
  _____
  If so, has this CPM faced prior warnings or disciplinary action? ☐ Yes ☐ No
  Please provide employee history, evaluations, etc. as appropriate.
- Have you contacted the CPM and/or employer about your complaint? ☐ Yes ☐ No
  If so, what action, if any, was taken or is being taken?
  _____
- Please describe in detail event(s) that caused you to file this complaint; include names, dates, locations, and any other information that you believe support the complaint. Attach extra pages if necessary.
  _____

  _____

I certify that the above information is true and correct to the best of my knowledge.

Signature of Complainant: _____Date: _____

Revised May 2018

ARTICLE 20:85

CERTIFIED PROFESSIONAL MIDWIVES

Chapter

ARTICLE 20:85:01

DEFINITIONS

Section

20:85:01:01. Definitions. Terms defined in SDCL chapter 36-9C have the same meaning when used in this article. In addition, the terms used in this chapter mean:

(a) "Consultation" the process where the client is seen face-to-face in a healthcare setting by a licensed medical doctor or doctor of osteopath. The consultation and any recommendation(s) shall be documented in the client's health record and acknowledged in writing by both client and Certified Professional Midwife (CPM);

(b) "Facility" a health care facility licensed pursuant to SDCL 34-12;

(c) "Physician" a medical doctor (M.D.) or doctor of osteopath (D.O.) licensed in good standing;

(d) "Postpartum" occurring in approximately the six (6) week period after childbirth; and

(e) "Preceptor" a maternity care provider currently practicing and licensed under SDCL 36-4, 36-9A, or 36-9C who is registered as a preceptor with the North American Registry of

Midwives (NARM) and provides instruction, training, and supervision to a student midwife licensed by the board.

Source:

General Authority: SDCL 36-9C-32.

Law Implemented: SDCL 36-9C-4.

ARTICLE 20:85:02

LICENSING

Section

20:85:02:01. Qualifications for licensure. No person may be licensed to practice as a certified professional midwife in this state unless the person has completed the requirements set forth in SDCL 36-9C-4. In addition, each applicant shall ensure that the board receives all documentation necessary to prove to the Board's satisfaction that the applicant meets all the requirements for licensure. Every applicant shall provide:

(a) Completed application and fee;

(b) Evidence they have not been convicted of a crime which in the judgment of the board renders the person unfit to practice midwifery;

(c) Fingerprints and other information necessary for a criminal history check;

(d) Applicant may be required to appear for a personal interview with the Board if deemed appropriate by the board.

Source:

General Authority: SDCL 36-9C-32.

Law Implemented: SDCL 36-9C-4; 36-9C-12.

20:85:02:02. Application for license by reciprocity. An applicant may seek licensure by reciprocity if they hold a license in good standing to engage in the practice of midwifery under the laws of another state provided:

(a) The applicant is currently licensed or certified by any state with requirements at least as stringent as South Dakota; and

(b) The applicant has not been sanctioned in another state without resolution satisfactory to the Board.

Source:

General Authority: SDCL 36-9C-32.

Law Implemented: SDCL 36-9C-4.

20:85:02:03. Background check required. Upon application for licensure, each applicant in this state shall submit to a state and federal criminal background investigation by means of fingerprint checks by the Division of Criminal Investigation and the Federal Bureau of Investigation. Failure to submit or cooperate with the criminal background investigation is grounds for denial of an application. The applicant shall pay for any fees charged for the cost of fingerprinting or the criminal background investigation.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-12.

20:85:03:04. Issuance of license. Licenses will be renewed biennially on October 30th.

Source:

General Authority: SDCL 36-9C-32

Law Implemented: SDCL 36-9C-11

20:85:02:05. Renewal of license. A notice for renewal of license shall be sent by the board to the last known address of each current licensee. Address may either be physical or electronic. Within the time provided in the notice, the following shall be submitted to the Board. Failure to receive the notice for renewal of license does not relieve the licensee of the responsibility for renewing the license and paying the renewal fee within the prescribed time. Any fee for renewal of license delivered in person to the board or postmarked after the filing date indicated in the notice shall not be accepted, and the license shall lapse. A lapsed license may be reinstated only in accordance with the provisions of SDCL 36-9C-17.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-15, 36-9C-16.

20:85:02:06. Relicensure. An applicant may seek relicensure if the applicant has been licensed in this state and either failed to timely renew or is seeking to return to active clinical practice. The following must be submitted at the time of reapplication:

(a) a completed application and payment of fee;

(b) a current CPM certification from NARM;

(c) satisfactory explanation for such failure to renew; and

(d) evidence of employment status during the preceding six years as described in SDCL 36-9C-16.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-16, 36-9C-17, 36-9C-18.

20:85:02:07. Inactive status. Upon filing with the board a written statement requesting inactive status and paying the fee prescribed by chapter 20:48:04, the licensee shall be placed on inactive status and issued an inactive status card. Reinstatement of an inactive license shall

follow the requirements set forth in 20:85:02:06. Any individual who holds inactive licensure status is prohibited from practicing as a certified professional midwife.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-18.

ARTICLE 20:85:03

THE PRACTICE OF CERTIFIED PROFESSIONAL MIDWIFERY

Section

20:85:03:01. Scope and practice standards. A licensed certified professional midwife shall adhere to the following scope and practice standards when providing antepartum, intrapartum, postpartum, and newborn care.

(1) The following conditions for which a licensed professional midwife may not provide care for a client:

(a) A current or unresolved previous history of any of the following disorders, diagnoses, conditions, or symptoms:

(1) Placental abnormality:

i. Confirmed central placenta previa at term;

ii. Signs indicative of placental abruption;

iii. Placenta located over previous uterine scar;

(2) Regular alcohol use or drug use, abuse, or dependency;

(3) Cardiac disease;

(4) Insulin dependent diabetes mellitus;

(5) Noncephalic presentation at the onset of labor or rupture of membranes, whichever occurs first, unless birth is imminent;

(6) Birth under thirty-seven (37) weeks or after forty-two (42) weeks gestational age;

(7) Current renal disease;

(8) Current liver disease;

(9) Pulmonary disease

(10) Active tuberculosis;

(11) Severe uncontrolled asthma;

(12) Seizure disorder requiring medication;

(13) Systemic lupus or scleroderma;

(14) Acute or chronic hepatitis;

(15) Congenital defects of the reproductive organs that would interfere with the birthing process;

(16) Chronic/essential hypertension;

(17) Gestational hypertension or pre-eclampsia

(18) Rh negative disease as indicated by positive titers;

(19) Failure to document the following:

a) basic prenatal lab work (blood group type, RH antibody screening, hemoglobin around 28 weeks gestation), or

b) signed refusal;

(20) Active TORCH infection during the first trimester;

(21) HIV positive;

(22) Suspected or diagnosed congenital fetal anomaly that may require immediate medical care after birth;

(23) Hemoglobin less than 10 at 36 weeks;

(24) Premature labor: less than 37 weeks;

(25) Serious viral/bacterial infection at term;

(26) Diagnosed intrauterine growth restriction;

(b) A past history of any of the following disorders, diagnoses, conditions, or symptoms;

(1) More than one (1) prior cesarean section with no history of a vaginal birth, a cesarean section within eighteen (18) months of the current delivery, or any cesarean section that was surgically closed with a classical or vertical uterine incision;

(2) Rh or other blood group or platelet sensitization, hematological or coagulation disorders;

(c) Unwillingness to accept midwife's limitations, prohibitions, and responsibilities for safe practice;

(d) Unresolved fearfulness regarding home birth or midwife care, or otherwise desires transfer of care; or

(e) Any other condition which may preclude the possibility of a normal birth, at the midwife's discretion.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-13.

20:85:03:02. Conditions where consultation is required. A certified professional midwife may not provide care for a client with a current history of disorders, diagnoses, conditions, or symptoms listed herein unless such disorders, diagnoses, conditions or symptoms are being treated, monitored or managed by a licensed physician. Before providing care to such a client, the licensed midwife shall notify the client in writing that the client shall obtain the described physician care as a condition to the client's eligibility to obtain maternity care from the certified professional midwife. The certified professional midwife shall, additionally, obtain the client's signed acknowledgement that the client has received the written notice. The disorders, diagnoses, condition, and symptoms are:

(1) Previous cesarean section;

(2) Diabetes requiring medication or not controlled by diet;

(3) Cervical insufficiency;

(4) Thyroid disease;

(5) Epilepsy;

(6) Hypertension;

(7) Cardiac disease;

(8) Pulmonary disease;

(9) Renal disease;

(10) Previous major surgery of the pulmonary system, cardiovascular system, urinary tract or gastrointestinal tract;

(11) Inactive hepatitis;

(12) Unresolved vaginal or urinary tract infection;

(13) Suspected size/dates discrepancies as defined by plus or minus 2 centimeters fundal height relational to week's gestation for two (2) consecutive prenatal visits;

(14) Observed maternal cardiac irregularities;

(15) Suspected pyelonephritis;

(16) Abnormal vaginal bleeding before onset of labor;

(17) Suspect thromboembolism or thrombophlebitis;

(18) Abnormal fetal heart tones detected prenatally;

(19) Marked decrease or cessation of fetal movement;

(20) Suspected or known postdates pregnancy beyond 42 weeks gestation;

(21) Non-reactive fetal stress test (NFT) after 28 weeks;

(22) Medically significant newborn anomaly;

(23) Newborn cardiac irregularity;

(24) 2 vessel cord;

(25) Jaundice within the first 24 hours;

(26) Failure to pass urine within the first 24 hours or failure to pass meconium within first 48 hours;

(27) Signs of umbilical infection unresponsive to treatment;

(28) Unresolved bleeding in excess of normal lochia flow;

(29) Subinvolution;

(30) Failure of laceration to heal properly or signs of infection unresponsive to treatment;

(31) Signs of serious postpartum depression or psychosis;

(32) Significant hematological disorders in the mother or newborn;

(33) Significant uterine or vaginal anomalies;

(34) Isoimmunization with an antibody known to cause hemolytic disease in the mother or the newborn;

(35) Suspected decreased amniotic fluid levels or an amniotic fluid index less than 5 centimeters in four quadrants or less than 2 centimeters in largest vertical pocket on ultrasound;

(36) Maternal or fetal skeletal abnormalities that would interfere with the birth process;

(37) Loss of greater than ten (10) percent birth weight in infant;

(38) Abnormal newborn screening;

(39) Primary outbreak of genital herpes during prenatal care; or

(40) The client or midwife requests such consultation.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-36.

20:85:03:03. Conditions where consultation shall be recommended. Before providing care for a client with a history of any of the disorders, diagnoses, conditions or symptoms listed, a certified professional midwife shall provide written notice to the client that the client is advised to see a licensed physician during the client's pregnancy. Additionally, the certified professional midwife shall obtain the client's signed acknowledgment that the client has received the written notice. The disorders, diagnoses, condition, and symptoms are:

(1) Previous complicated pregnancy;

(2) Diabetes controlled by diet;

(3) Previous pregnancy loss in second or third trimester;

(4) Previous spontaneous premature labor;

(5) Previous preterm rupture of membranes;

(6) Previous preeclampsia;

(7) Previous hypertensive disease of pregnancy;

(8) Prior infection with parvo virus, toxoplasmosis, cytomegalovirus or herpes simplex virus;

(9) Previous newborn group B streptococcus infection;

(10) A body mass index of forty-five (45.0) or greater at the time of conception;

(11) Underlying family genetic disorders with potential for transmission;

(12) Psychiatric illness; or

(13) Maternal age under 16 years or over 42 years.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-36.

20:85:03:04. Conditions where maternal transfer to hospital shall be facilitated. A certified professional midwife shall facilitate the immediate transfer of a client to a hospital for emergency care if the client has any of the following disorders, diagnosis, conditions or symptoms:

(1) Infection during labor or immediately postpartum where maternal temperature is above 100.8 degrees Fahrenheit for two consecutive readings in one hour and foul smelling amniotic fluid, shaking, chills, or elevated pulse are present;

(2) Suggestion of fetal jeopardy, such as any abnormal bleeding (with or without abdominal pain), evidence of placental abruption, thick meconium , or abnormal fetal heart tones with non-reassuring patterns where birth is not imminent;

(3) Inability to obtain fetal heart tones after twenty (20) weeks gestation or anytime later in pregnancy;

(4) Noncephalic presentation at the onset of labor or rupture of membranes, whichever occurs first, unless birth is imminent;

(5) Second stage labor after three (3) hours without adequate progress, and third stage labor after one (1) hour without adequate progress;

(6) Current spontaneous premature labor;

(7) Current preterm premature rupture of membranes;

(8) Signs of pre-eclampsia or eclampsia;

(9) Current hypertensive disease of pregnancy;

(10) Continuous uncontrolled bleeding;

(11) Suspected placenta accreta;

(12) Hemorrhage not responsive to treatment;

(13) Unresolved maternal shock;

(14) Cord prolapse;

(15) Active herpes during labor;

(16) Transverse in labor;

(17) Excessive antepartum and intrapartum painless vaginal bleeding;

(18) Cardiac arrest;

(19) Delivery injuries to the bladder or bowel including third and fourth degree lacerations;

(20) Seizures;

(21) Uncontrolled vomiting;

(22) Coughing or vomiting of blood;

(23) Severe chest pain or cardiac irregularities;

(24) Apnea;

(25) Persistent uterine atony;

(26) Uterine inversion;

(27) Indications of infection in the immediate postpartum;

(28) Tremors, hyperactivity, or seizures;

(29) Declining O2 stats or tachypnea unable to be resolved; or

(30) Client desires transport for herself or her newborn.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-36.

20:85:03:05. Conditions where newborn transfer to hospital shall be facilitated. A certified professional midwife shall facilitate the immediate transfer of any newborn to the nearest hospital or pediatric care provider if the newborn has any of the following disorders, diagnosis, conditions or symptoms:

(1) Apgar score of 6 or less at 10 minutes of age and not improving;

(2) Significant medical anomaly requiring immediate medical attention;

(3) Birth weight of less than 5 pounds;

(4) Tremors, hyperactivity, or seizures;

(5) Abnormal color in newborn, persistent central cyanosis;

(6) Unresolved abnormal cry in newborn;

(7) Obvious or suspected birth injury;

(8) Newborn cannot maintain body temperature;

(9) Inability of newborn to feed well due to lethargy;

(10) Newborn temperature of 100.8 two consecutive readings ten (10) minutes apart;

(11) Signs of respiratory distress including respiratory rate over eight (80) per minute, poor color, grunting , nasal flaring or retractions unable to be resolved with usual interventions within one (1) hour postpartum ;

(12) Need for oxygen for more than twenty (20) minutes, or after one (1) hour following the birth;

(13) Fontanel full and bulging;

(14) Cardiac irregularities including heart rate that is consistently below eighty (80) beats per minute or greater than one hundred sixty (160) beats per minute and poor capillary refilling greater than three (3) seconds;

(15) Jaundice at less than twenty-four (24) hours; or

(16) Client desires transport for newborn.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-36.

20:85:03:06. Emergency transport and transfer plan. When facilitating a transfer, the certified professional midwife shall notify the hospital when the transfer is initiated, accompany the client to the hospital if feasible, or communicate by telephone with the hospital if the certified professional midwife is unable to be present. The certified professional midwife shall also ensure that the transfer of care is accompanied by the client's medical record, which shall include:

(1) The client's name, address, and next of kin contact information;

(2) A list of diagnosed medical conditions;

(3) A list of prescription or over the counter medications regularly taken;

(4) A history of previous allergic reactions to medications; and

(5) Required transfer form.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-36.

20:85:03:07. Record keeping. Each client record shall be retained for a minimum of ten (10) years after the birth during which time reasonable efforts are to be made to advise clients of closure of practice or change in record location.

Source:

General Authority: SDCL 36-9C-32.

Law Implemented: SDCL 36-9C-13.

20:85:03:08. Newborn care. Certified professional midwives shall adhere to the following requirements:

(1) Shall carry the equipment necessary for resuscitation of the newborn; and

(2) All certified professional midwives shall comply with all newborn screenings required by state law and administrative rule.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-13, 36-9C-35, 36-9C-37.

20:85:03:09. Medical waste. Medical waste removed from a private residence shall be disposed of according to local, state, and federal regulations.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-13.

20:85:03:10. Professional standards. Persons licensed by the board shall:

(1) Use the term "Certified Professional Midwife" and/or the initials "CPM;"

(2) Practice in a manner that is in the best interest of the public and does not endanger the public health, safety or welfare;

(3) Render services to clients, as necessary, for routine perinatal care, or diagnostic or therapeutic purposes;

(4) Practice only within the competency areas for which they are trained and experienced. The licensee shall be able to demonstrate to the board competency, training, and/or expertise;

(5) The licensee shall provide to the client written informed consent documents in accordance with SDCL 36-9C-33.

(6) Report to the board outcomes of all clients for which they have provided services at any point during labor or delivery within thirty (30) days after each birth;

(7) Report to the board known or suspected violations of the laws and regulations governing the practice of licensed professionals;

(8) The licensee shall make provisions for the retention and/or release of client records. If the licensee is unable to do so, such provision shall include the naming of a qualified person who will retain the client records and properly release the client records upon request;

(9) Clearly state the person's licensure status by the use of a title or initials such as "certified professional midwife (CPM)" or a statement such as "licensed by the South Dakota Board of Certified Professional Midwives" in any advertising, public directory or solicitation, including telephone directory listings;

(10) Respond to all requests for information and all other correspondence from the board;

(11) Not permit, condone or facilitate unlicensed practice or any activity which is a violation of these rules and regulations;

(12) Not use vacuum extraction or forceps as an aid in the delivery of a newborn; and

(13) Not perform abortions.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-13.

ARTICLE 20:85:04

FEES

Section

20:85:04:01. Initial licensure. Each person licensed to practice in this state shall, or who holds an endorsement from another state, shall pay an initial licensure fee of $1,000.

Source:

General Authority: SDCL 36-9C-32

Implemented Law: SDCL 36-9C-19

20:85:04:02. Biennial renewal. Each person licensed to practice within this state shall renew the license biennially on October 31st. The renewal fee is $1,500. Failure to secure a renewal certificate shall result in a lapse. A lapsed license may be reinstated in accordance with 20:85:03:06.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-19.

20:85:04:03. Lapsed license. For reinstatement of a lapsed license, the lapsed license holder shall pay the current renewal fee plus five hundred dollars.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-19.

20:85:04:04. Student license. Each certified professional midwife student who seeks licensure while completing certification requirements shall pay a one-time fee of $500.

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-19.

20:85:04:05. Inactive license status. Any licensed certified professional midwife who is licensed in this state and who wishes to change the status of their license to inactive shall pay a fee of $100.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-19.

20:85:04:06. Other fees. Any person licensed in this state and who has the following requests shall pay the stated fee:

(a) For providing a transcript, $25;

(b) For a name change on a record of the license holder, $100;

(c) For issuance of a duplicate license, $100;

(d) For endorsement to another state, territory or foreign country, $150;

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-19.

20:85:04:07. Birth delivery fee. The certified professional midwife shall pay a birth delivery fee of $100 accompanied by the birth reporting form, within 30 days of delivery.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-19.

ARTICLE 20:85:05

DISCIPLINARY PROCEDURES

Section

20:85:05:01. Board action in general. The board, through a designated investigator shall promptly investigate all complaints filed in writing with the board or the disciplinary committee and violations which come to the attention of one or more board members.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-22, 36-9C-27, 36-9C-5.

20:85:05:02. Grounds for denial, revocation, or suspension. The board may deny, revoke, or suspend any license or application for licensure to practice as a certified professional midwife or certified professional midwife student in this state, and may take other disciplinary or corrective action upon a showing that the license holder or applicant has committed or violated any of the provisions set forth in 36-9C-22.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-22, 36-9C-5.

20:85:05:03. Unprofessional conduct. Willfully practicing beyond the scope of practice, violating the terms of suspension or probation ordered by the board or following a course of conduct or practice in violation of SDCL 36-9C or in violation of this article constitutes unprofessional conduct.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-22, 36-9C-27, 36-9C-5.

20:85:05:04. Reissuance of a revoked or suspended license. A person whose license has been suspended, revoked, surrendered, restricted, conditioned, or otherwise disciplined under the provisions of 20:85:05, may apply for reinstatement once a year or at such shorter intervals as the board may direct in the order of suspension or any modification thereof. Upon receipt of an application for reinstatement, the board may take or direct any action necessary to determine whether the person's disability has been removed, including the examination of the person by a qualified medical expert designated by the board. The person may be directed to pay the expense of the examination. The application for reinstatement shall be granted by the board upon determination that the person's disability has been removed and he or she is fit to resume the practice of certified professional midwifery. The following application reinstatement requirements shall apply:

(a) Submit a completed reinstatement application and payment of fee;

(b) Submit evidence of complying with any requirements of a previous Board order;

(c) Submit evidence that the applicant has corrected the conduct that formed the basis of the discipline of applicant's license and the applicant is able to safely, skillfully, and competently practice; and

(d) Submit evidence demonstrating just cause for reinstatement.

The Board may request that the applicant appear before the Board if deemed necessary by the Board.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-26, 36-9C-5.

20:85:05:05. Disciplinary complaints. The board, through its investigator shall promptly investigate any complaints of misconduct or violations filed in writing and signed by a complaining party. The board shall impose appropriate sanctions as established under this chapter to protect the public health, safety, and welfare of the state of South Dakota. The board may also by resolution initiate disciplinary proceedings.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-5.

20:85:05:06. Actions which may warrant sanctions. The board may impose sanctions based upon any of the following:

(1) Engaging in conduct outside the scope of certified professional midwifery practice including any conduct or practice contrary to recognized standard of ethics of the certified professional midwifery profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any conduct, practice, or condition which does or might impair a certified professional midwife's ability to safely and skillfully practice professional midwifery;

(2) Failure to continue professional education or failure to participate in the required continuing education courses as provided under the provisions of chapter 20:85(will add in when education chapter is written);

(3) Failure to maintain current knowledge of statutes, rules, and regulations regarding the practice of professional midwifery;

(4) Failure to cooperate with and respond in writing within 15 days after personal receipt of any board inquiry or investigation;

(5) Failure to maintain proper patient records on each patient. Patient records must be clear and legible and include:

(a) A description of the patient's complaint;

(b) A history;

(c) A record of diagnostic and therapeutic procedures; and

(d) A record of daily documentation which must include subjective data, objective data, assessment, and plan for the patient's care;

(6) Failure to properly train and supervise staff engaged in patient care;

(7) Conviction of a felony or misdemeanor involving moral turpitude. A copy of the record of conviction certified to by the clerk of the court entering the conviction is conclusive evidence of the conviction;

(8) Fraud, misrepresentation, or deception include the following:

(a) Practicing or attempting to practice professional midwifery under a false or assumed name;

(b) Aiding, assisting, or advising another in the unlicensed practice of professional midwifery;

(c) Fraud or deceit in obtaining a license to practice professional midwifery;

(d) Making false or misleading statements or withholding relevant information regarding the qualifications of any individual in order to attempt to obtain a license or engage in the practice of professional midwifery;

(e) Failing to report past, present, or pending disciplinary action by another licensing board or current status of final administrative disposition of a matter. A licensee is required to report any compromise or settlement of disciplinary action, whether voluntary or involuntary, which results in encumbrance of licensure;

(f) Making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, or willfully impeding or obstructing another person to do so; or

(g) Submitting to any insurer or third-party payor a claim for a service or treatment which was not actually provided to a patient;

(9) Habitual intemperance in the use of intoxicants or controlled substances to such an extent as to incapacitate the person from the performance of professional duties;

(10) Exercising influence on the patient or client for the purpose of financial gain of the licensee or a third party;

(11) Improperly interfering with an investigation or inspection authorized by statute or under the provisions of article 20:85 or with any disciplinary proceeding;

(12) Repeated violations of this chapter;

(13) Receiving three or more negative peer reviews within any twelve-month period.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-22, 36-9C-23, 36-9C-27, 36-9C-5.

20:85:05:07. Disciplinary procedures. Disciplinary procedures shall be initiated by submission of a written complaint or by resolution of the board. Disciplinary procedures shall be conducted as follows:

(1) Each written complaint or board resolution for disciplinary investigation shall be given to the board investigator. The investigator shall investigate and prepare a report to be presented to the board;

(2) The investigator shall acknowledge receipt of the complaint;

(3) The investigator shall notify the certified professional midwife that a complaint has been received and request a response within 15 days to be mailed to the investigator. The notice shall include the basis for the complaint, including the name of the complaining party, and the name of the investigator assigned to investigate the complaint. A copy of these rules of procedure shall accompany the notice. The certified professional midwife shall promptly and appropriately respond to any request of the investigator;

(4) The investigator shall notify the complainant that the certified professional midwife has been notified of the allegations and requested to respond within 15 days and that the response shall be forwarded to the complainant;

(5) The investigator shall prepare a report to present to the board. The report shall include the identity of the complainant, the allegations which form the basis of the complaint, the position of the certified professional midwife against whom the complaint is lodged, and the proposed action, if any, that should be taken with regards to the complaint;

(6) Upon presentation of the report to the board, the board shall review the report and act upon the information before it, in one of the following manners, to-wit:

(a) Dismiss the complaint if frivolous or clearly unfounded in fact; or

(b) Initiate an informal inquiry or take such further action as the board deems appropriate;

(7) If the board dismisses the complaint, the investigator shall give notice to the complainant and the certified professional midwife that the complaint has been reviewed with the determination that no board action is warranted;

(8) If the board finds the complaint to have merit, the committee shall afford the certified professional midwife complained against a reasonable opportunity to state the certified professional midwife's position with respect to the allegations against the professional. The

hearing shall take the form of an informal conference between the board and the certified professional midwife complained against; and

(9) After an informal inquiry, the board may dismiss or, if the complaint has merit, refer for a formal hearing. In lieu of referral for hearing, the board and the certified professional midwife may enter a remedial stipulation satisfactory to both the certified professional midwife and the board. If a remedial stipulation is entered, the referral may not take place if the terms of the remedial stipulation are successfully completed and the board shall notify the complainant that the matter has been resolved in this manner. The complainant is not entitled to a copy of the remedial stipulation.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-5.

20:85:05:08. Procedures referred for formal hearing. A formal hearing may be conducted by the board, or a hearing examiner, pursuant to SDCL chapter 1-26.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-5.

20:85:05:09. Sanctions. The board may impose any of the following sanctions or a combination thereof:

(1) Formal reprimand;

(2) Probation of license to practice professional midwifery in the state of South Dakota;

(3) Suspension of license to practice professional midwifery in the state of South Dakota;

(4) Revocation of license to practice professional midwifery in the state of South Dakota; or

(5) Restitution and payment of all expenses of the investigation and proceedings.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-5.

20:85:05:10. Judicial declaration of incompetence or involuntary commitment. If a person licensed or certified by this board has been judicially declared incompetent or involuntarily committed to a mental hospital or treatment center, the board of certified professional midwives, upon proof of the fact, shall enter an order either placing the person on inactive status or suspending the person from the practice of professional midwifery for an indefinite period until further order of the board. A copy of the order shall be served upon the person, the person's guardian, and the director of the mental hospital by certified mail, return receipt requested.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-29, 36-9C-23, 36-9C-5.

20:85:05:11. Petition by board. If any interested person petitions the board or the disciplinary committee to determine whether a person licensed or certified by this board is incapacitated by reason of mental infirmity or illness or because of addiction to drugs or intoxicants, the board may take action to determine whether the person is so incapacitated, including the examination of the person by such qualified medical experts as the board designates. If the board concludes that the person is incapacitated from continuing to practice professional midwifery, it shall enter an order either placing the person on inactive status or suspending the person on the ground of the disability for an indefinite period until further order of the board. Any pending disciplinary proceeding against the person shall be held in abeyance. The board shall provide notice to the respondent of proceedings in the matter in accordance with SDCL chapter 1-26 and may appoint an attorney to represent the respondent if the person is without representation.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-24, 36-9C-29, 36-9C-5.

20:85:05:12. Burden of proof. In a proceeding seeking an order of inactive status, probation, or suspension based upon the reasons set forth under 20:85:05:11 or 20:85:05:12, the burden of proof shall rest with the party filing the complaint. In a proceeding seeking an order terminating inactive status or suspension, the burden of proof shall rest with the person who is inactive or suspended.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-5.

20:85:05:13. Respondent's claim of illness or infirmity. If, during the course of a disciplinary proceeding, the respondent contends that he is suffering from a disability by reason of mental or physical infirmity or illness or addiction to drugs or intoxicants, which makes it impossible for the respondent to present an adequate defense, the board shall enter an order immediately suspending the respondent from continuing to practice professional midwifery until a determination is made of the respondent's capacity to continue to practice in a proceeding instituted in accordance with the provisions of 20:85:05:13. If the board determines that the respondent is not incapacitated from practicing, it shall take such action as it deems advisable, including a direction for the resumption of the disciplinary proceeding against the respondent.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-24, 36-9C-5.

20:85:05:14. Doctor-patient privilege -- Waiver. The filing of an application for reinstatement by a person placed on inactive status or suspended for disability constitutes a waiver of any doctor-patient privilege with respect to any treatment of the person during the period of disability. The person shall disclose the name of every psychologist, physician, and hospital by whom or in which the person has been examined or treated since being placed on inactive status or suspension. The person shall furnish to the board written consent to each to divulge the information and records requested by board-appointed medical experts.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-5.

20:85:05:15. Judicial declaration of competence. If a person has been suspended by an order in accordance with the provisions of 20:85:05:11 or 20:85:05:12, and has thereafter been judicially declared to be competent, the board may dispense with further evidence showing the disability has been removed and may direct reinstatement.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-5.

20:85:05:16. Suspension and probation. The period of probation or suspension ordered pursuant to § 20:85:05:11 or 20:85:05:12 may not exceed five years. The conditions of probation may include one or more of the following:

(1) Additional mandatory continuing education;

(2) Restitution;

(3) Payment of all expenses of the investigation and proceedings; and

(4) Mental health or alcoholism treatment.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-5.

20:85:05:17. Formal reprimands and files. The board shall keep a permanent file of all complaints made to or by the board which result in an inquiry being directed to a licensee and a permanent file of board action taken, including formal reprimands. In considering action in a case, the board shall take into consideration at the hearing the past actions of the licensee or holder of a certificate, extending an opportunity to the person to rebut or explain such past actions and files. The files are confidential except to board members acting within the scope of their duties and to the person or person's attorney or representative desiring to see the person's file.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-5.

20:85:05:18. Board hearings -- Procedure. Those portions of the rules of practice in trial courts of record and those portions of SDCL 15 and 1-26 that are consistent with SDCL 36-5 or this article apply to the procedure for hearings held by the board. A record of the hearing in a contested case shall be taken by court reporter or recording equipment. If a transcript is requested, the board may require the person requesting it to pay the reasonable cost of preparing the transcript.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-23, 36-9C-5.

20:85:05:19. Appeal from board rulings or decisions. Any party feeling aggrieved by any acts, ruling or decision of the board relating to the refusal to grant, suspend or revoke a license shall have the right to appeal pursuant to chapter 1-26.

Source:

General Authority: SDCL 36-9C-32.

Implemented Law: SDCL 36-9C-25.

May 5, 2018

Ashley Tanner, JD
Division of Administration
South Dakota Department of Health
600 East Capital Ave
Pierre, SD 57501

RE: Board of Certified Professional Midwives Draft Administrative Rules

Dear Ms. Tanner:

Thank you for the opportunity to provide comments on the Board of Certified Professional Midwives draft administrative rules. The practice of midwifery is not without risk of serious injury – up to and including death of the mother and/or newborn. SDSMA believes it is critical that the rules appropriately address and mitigate those risks to the extent possible.

Upon medical review of the draft proposals, and having surveyed the requirements of other states where the practice of midwifery by certified midwives is permitted, we respectively ask for staff's consideration of the following comments on the draft rules:

1. Proposed 20:85:02:02 allows for licensure by reciprocity. There is no statutory authority for such licensure by the Board of Certified Professional Midwives. When the Legislature intends to allow for licensure by reciprocity, it says so explicitly. See SDCL 36-4-19; 36-5-13; 36-24-46; and 36-32-16. There is no similar authorizing provision in SDCL Ch. 36-9C.

2. The statute authorizes a Certified Professional Midwife ("CPM") to "manage and care for the low-risk mother-baby unit …." SDCL 36-9C-1(3). "Low risk" is then defined as "a pregnancy that is anticipated to be problem free …." SDCL 36-9C-1(6). There is no definition of "problem free," so that term must be construed and interpreted based on its usual and ordinary meaning. The provisions of the draft rules that allow for a CPM to continue to care for a mother-baby unit with a history of "problems" relating to pregnancy (e.g., 20:85:03:03) is not consistent with the statute, and we respectfully assert, is prohibited by the statute. If there is a history of problems relevant to the pregnancy that warrant a referral to a physician, the pregnancy is clearly not "problem free" and the CPM may not continue to provide care for the mother-baby unit.

3. 20:85:03:01(1)(a)(1) Placental abnormality – no expecting mother with placental abnormality should be considered a candidate for services provided by a CPM. Signs indicative of placental abruption should require an emergent referral as soon as they appear; once those signs are present, the attendant has approximately ten (10) minutes to complete a delivery. And while we agree that women in which the placenta is located over a pre-existing uterine scar should not be candidates for services from a CPM, this condition requires an ultrasound for detection. Women with this condition – placenta located over previous uterine scar – are at higher risk for uterine rupture, and the death of both the mother and baby may occur without emergency cesarean section capabilities.

4. 20:85:03:01(1)(a)(4) – This provision should be extended to include all diabetics. Diabetes is an independent risk factor for shoulder dystocia, even in normal-weight babies, and it's a common cause of neonatal hypoglycemia in the immediate newborn period. Diabetes is also a risk factor for intrauterine fetal demise. If a total transfer of care is not required for a diet-controlled diabetic, a consultation with a physician should be required.

5. 20:85:03:01(1)(a)(19) – Failure to document basic prenatal lab work or signed refusal – failure to document is not consistent with the notion that a pregnancy must be "problem free" in order for the CPM to provide care. Every expecting mother with abnormal screening labs should be added to the list in which a referral is required. Moreover, the screening for syphilis, HIV, Hepatitis B should be added to the list of basic prenatal lab work.

6. 20:85:03:01(a)(a)(19) – With respect to subsection 19(b), we read that to mean a CPM may continue to treat a mother-baby unit if the CPM documents the mother's refusal to consent to blood testing. While a refusal to consent to blood testing may be within the mother's prerogative, a CPM may not provide care unless the pregnancy is "problem free." It is not possible to determine if the pregnancy is "problem free" absent such testing. Accordingly, the refusal of the mother to consent to blood testing should be grounds to refer the mother-baby for care by a physician.

7. 20:85:03:01(1)(a)(20) – Both "Active" and "TORCH" should be defined. With respect to "TORCH," the term should be defined to include toxoplasmosis, syphilis, rubella, cytomegalovirus, herpes simplex virus, parvovirus, varicella, listeria, and zika.

8. 20:85:03:01(1)(a)(22) – We question how a CPM will detect a suspected or diagnosed congenital fetal anomaly that may require immediate medical care after birth without a prior ultrasound. The rules should specify how screening for such an anomaly will be conducted and by whom.

9. 20:85:03:01(1)(a)(23) – Thrombocytopenia (platelets less than 150,000) should be added.

10. 20:85:03:01(1)(a)(25) – Serious viral/bacterial infection at term. We believe the word, "serious" is subjective and should be removed. Any infection at the time of delivery puts a newborn at risk of becoming very sick.

11. 20:85:03:01(1)(a)(26) – Diagnosed intrauterine growth restriction. We believe the word, "diagnosed" should be removed and replaced with "suspected." In doing so, we also ask that growth restriction be defined at an estimated fetal weight less than the 10th percentile for gestational age and add and define macrosomia (an estimated fetal weight greater than the 90th percentile for gestational age or greater than 4500g). An ultrasound is required to detect/diagnose an intrauterine growth restriction. The rules should specify how screening for such an anomaly will be conducted and by whom.

12. 20:85:03:02(1)(b) – While the CPM may be able to provide care during delivery, it is critical that any woman who has a prior cesarean section deliver in a facility with the capability to perform a cesarean section within ten (10) minutes.

13. 20:85:03:02(1)(b)(1) – In addition to a prior cesarean section, prior myomectomy in which the uterine wall was significantly disrupted or in which the operative report is unavailable to confirm the extent of the disruption be added to this list.

14. 20:85:03:02 – While we agree that patients who have had a previous major surgery of the pulmonary system, cardiovascular system, urinary tract and/or gastrointestinal tract require a consultation, previous surgeries of the reproductive or genitourinary tract should also be added to this list.

15. 20:85:03:02(2) – Any expecting mother with diabetes should be referred to a physician.

16. 20:85:03:02(19) – The word, "marked" is subjective and should be removed.

17. 20:85:03:02(27) – Since omphalitis can be associated with sepsis and requires IV antibiotics, the words, "unresponsive to treatment" be removed so that anyone with signs of umbilical infection is referred.

18. 20:85:03:02(39) – Any current outbreak – whether primary or secondary – should require referral as there are clear screening protocols for the baby that are designed to prevent severe infant disease – even when mothers are asymptomatic.

19. 20:85:03:03 generally. As noted earlier, a CPM may only provide care when the pregnancy is anticipated to be "problem free." Accordingly, all of the conditions listed call for a mandatory referral, not a mere recommendation.

20. 20:85:03:03(10) – Anyone with a BMI greater than 40 – which is the definition of Class III obesity – should require referral. Maternal obesity is associated with increased risk of congenital fetal anomalies including heart defects, neural tube defects, and hydrocephalus. Other potential anomalies include diabetes, hypertension, and growth abnormalities. Of note, obese women are 40 percent more likely to experience intrauterine fetal demise than normal-weight women.

21. 20:85:03:04 – The National Institute of Child Health and Human Development's definition of chorioamnionitis, which is endorsed by ACOG, should be used. The definition is as follows: A presumptive diagnosis of Intra-Amniotic Infection can be made in women with:

a. Fever – greater than 39.0 degrees Celsius (102.2 degrees Fahrenheit) or 38.0 degrees C (100.4 degrees F) to 38.9 degrees C (102.02 degrees F) on two occasions 30 minutes apart, without another clear source PLUS one or more of the following:
    i. Baseline fetal heart rate greater than 160 beats/minute for greater than or equal to 10 minutes, excluding accelerations, decelerations and periods of marked variability
    ii. Maternal white cell counts greater than 15,000mm^3 in the absence of corticosteroids and ideally showing a left shift (bandemia)
    iii. Purulent-appearing fluid coming from the cervical os

22. 20:85:03:04(6) – This should say "preterm" labor.

23. 20:85:03:05(11) – This appears to be a typographical error and it should say, "eight " per minute.

24. 20:85:03:06 – In addition to the required documentation listed, there should to be a requirement for a clinical note describing the events leading to the transfer.

25. 20:85:03:07 – The record keeping requirement should be equal to or at least one year greater than the state's statute of limitations for birth injury.

26. 20:85:03:08 – A requirement that CMPs be certified in neonatal resuscitation should be included.

27. 20:85:03:10(6) – The requirement to report services and outcomes should be extended to the standard postpartum period, which is defined as 42 days after birth.

Thank you for your consideration of these comments. Please let us know if you would like to see medical literature to support the substantive medical proposals, or if you have any questions.

Sincerely,

Barbara Smith, CEO
South Dakota State Medical Association

CC: Robert VanDemark Jr, MD, SDSMA President

Dear Ms. Tanner,

I am a Certified Nurse Midwife practicing in the state of Iowa. My experience with Certified Professional Midwives has been met with profound respect for their knowledge, experience and competency in their care of well women during the childbearing year and beyond. In fact, the rigorous training required by their professional certifying board surpasses the training I had received.

Likewise, the requirements for their continuous re-certification surpasses requirements imposed upon my profession. I am completely confident in their professional board's ability to ensure that their members remain safe practitioners for the community.

Upon reviewing South Dakota's proposed rules for the practice of midwifery, I found it to be unnecessarily burdensome and, frankly, insulting to Certified Professional Midwives' clinical judgement. I propose that all the minutiae of standards of care be removed from the rules and left to their professional organization. We do not want to go down a road where government trumps clinical decision making of clinicians and the families they serve.

Likewise, I propose the the annual fee for licensure be imposed in an equitable manner, as compared to other health professionals. In my state, I pay about $120 per year, and am not penalized with an additional fee per birth. Are doctors or other health professional required to pay a government fee per patient? If not, then this undue requirement is discriminatory in nature and designed to obstruct the professional practice of midwifery in the state of South Dakota.

I hope and pray that the families of South Dakota will be given a wide array birth options, including the excellent care of Certified Professional Midwives.

Thank you for considering my suggestions.

Nicole Marie Josselyn, CNM

Ashley,

Attached please find my thought on the new CPM rules and regulations that are proposed. You are treating CPMs as if we have no more training than a nurse's aide.. I pray that you will carefully consider them. This is such an important issue for me and many others, especially families desiring home births in South Dakota. I have no problem showing that I have the knowledge and skills to be a good midwife. It is the very reason why I became a CPM in the first place. Please carefully consider the comments that are put forth.

Sincerely,

Judy Kay Jones, CPM, ND

Debbie,

Here are my comments on your proposed rules for CPMs. I hope you will strongly consider them. It makes me very sad to read them. It probably means I will never practice as a CPM in South Dakota, even though I already jumped through your requirements to get a Briidge certificate. I just finished spending over $1000 to fly to Vermont to redo my NRP with Karen Strange. It really makes me very sad. I am certain now that the board would use 20:85:02:01 (b) to use my misdemeaner conviction as the board's judgment that I would not be qualified to be licensed.

Following are my comments on the rest of your work

20:85:03:01 Scope and Practice Standards

I looked at the South Dakota CNM requirements of practice. Theirs is a one page list of what they CAN do, with those same things listed in the collaborative agreement of what they CAN do. Your CPM practice standards are nearly 30 pages (will be more by the time you add other things) of what a CPM CANNOT do! It is a laundry list of everyone to whom they cannot provide care. Why do you believe you need such a list for CPMs? You must believe that CPMs are so stupid or uneducated to not make good judgments as to when a mother or baby needs to be referred to a doctor for further care. THAT IS NOT TRUE!!! The requirements to become a CPM actually require more hands on care in birth than is needed to become a CNM or even a doctor. If someone has that poor of judgment, they would not even be eligible to become a CPM.

Many of the things listed would have automatically disqualified the client from being accepted by a CPM for care without any such list. Other areas are ones for which we should be able to provide care and consult with a doctor as we believe is needed. Some other areas, CPMs should be able to handle if they have experience in that area.

Vaginal breech delivery is one of those areas. In Great Britain vaginal breech is considered a normal delivery. They have teams who work specifically with breech deliveries. They consider anyone who has attended 13 to 15 vaginal breech deliveries to be competent to do breech and anyone who has done 20 or more vaginal breech deliveries to be an expert.

Yet you make no distinction in experience levels. The truth is that many CPMs are more experienced in vaginal breech delivery than are the doctors.

Also, CPMs cannot provide care for someone over 42 weeks of pregnancy. Yet it is again listed on the area of required consultation. Which is it? Forbidden or required consultation? What if the client refuses to go to the doctor and be induced.

I know that the one study showed a higher mortality among those babies over 42 weeks. However that study did not distinguish between those who were induced with medical intervention after 42 weeks, or induced by a more natural means like castor oil and those who were allowed to proceed to natural

delivery. I wrote to the authors and asked about it, but no one ever bothered to reply. That is a glaring problem in the study.

Another question, What if a mom has been under a doctor's care for essential hypertension and her blood pressure is staying in normal range. If the doctor says it is OK for a home birth, why are CPMs forbidden from providing her care?

CPMs must document prenatal blood work on everyone, yet have no authority to order blood work at a lab. So a CPM would need to send every client to a CNM or a doctor just to get blood work done.

You have basically forbidden CPMs form attending a VBAC for anyone with more than one C-Section. What do these women do? They will end up at home unattended by anyone. If we even advise them in any way, we lose our license. Where is the medical evidence supporting this?

Some things are listed in the forbidden area and then listed in the required consultation area. Which is it? And where is the wisdom of personal discernment and judgment as a trained professional taken into account.

Often I give supplements to support thyroid function for many women to help prevent miscarriage. A doctor would not diagnose it as thyroid disease - but technically it is. It may not show on the TSH blood work, but it does on their basal temperature testing. The doctor would instead just put them on progesterone hormone. Are we forbidden from helping prevent miscarriage?

Any midwife worthy of being a CPM knows enough to transport a mom or baby in to a doctor without this detailed list in scope of practice.

A question about primary genital herpes outbreak in pregnancy. Is this based on recent research? I have heard that if it is not present at birth, it may be OK to deliver vaginally. Very rarely do I even see a client with this history.

20:85:03:03 Do CPMs have to give the client a WRITTEN list of all these things we must send them in for consult?

(8) Herpes simplex? Why do we need to send a mom in who for consult who has a history of chicken pox or cold sores? Is this evidenced based?

(13) Mothers over 42 year of age must be sent for a consult. Why??

20:85:03:04 (1) thick meconium - Are you aware of the new information on meconium? Even NRP has changed its recommendations in this area.

(5) Second Stage Three hour limit. Why? Evidence? Often they have not been pushing all that time and the baby is simply molding to fit out. Or it may be a compound presentation in which there is no urge to push until they are on the perineum. Some moms will have a cervical lip that needs time to resolve. Most CPMs do not have a mom pushing until she has the natural urge. So we may see longer second stages with no adverse effects. Most CPMs do not do frequent pelvic exams (sometimes we do

none in a birth). so how do we know they are in second stage? Are CPMs now required to do pelvic exams every hour? What if the mother is doing fine and refuses to transport? Does a CPM walk off and leave the mother to protect her own license her license?

20:85:03:05 Transport of Newborn

(3) Birth weight under 5# What if a baby is SGA and doing well and parents refuse to transport? Do we call 911 and force them to transport or what? If the baby is in distress of any kind, that is different. But with SGA babies, they are small, but mature.

20:85:03:08 Newborn Care

You do not define what equipment is required to be carried? Our knowledge of CPR and NRP outside of a hospital is far more valuable than any equipment. Would a CPM have to carry O2 and a regulator? Or just an ambu bag? What if the midwife feels more comfortable doing mouth to mouth , not using an ambu bag?

Newborn Screening - Does the CPM have access to the cards or have the ability to order it done at a hospital lab? That needs to be addressed if we are required to do them.

20:85:03:09 Medical Waste Are you referring to needle disposal? Or are you referring blood on chux pads? What about the placenta? More and more moms are now deciding to encapsulate their placentas. Are they not allowed to do this? Some CPMs may even do encapsulation.

20:85:03:10 Professional Standards

(3) Diagnostic and therapeutic -- Are we actually allowed to Diagnose? Wow!

(4) Trained and experienced -- If we are trained and experienced, then why are CPMs restricted from breech , twins, and VBACs? What is your standard for trained and experienced?

(6) Report – Do you have a form to use? How are we to report and to whom?

20:85:05:06 (2) educational continuing education requirements. Are you imposing more requirements than CPMs already have to maintain their CPM recertification? You do realize that CPMs have much more stringent requirements for recertification than RNs or CNMs have to maintain their certification. RNs and CNMs do not even need NRP certification, unless is required by the hospital that employs them. If they do home births, there is no requirement for NRP.

(6) A CPM could lose her license if she even advises someone who is unlicensed. In some states there is no licensure for CPMs or licensure is voluntary. ND, MN, IA, NE & KS all fit in those categories. Many midwives practice in those states who often ask advice of one another in unusual situations. To make that a criminal offense is wrong! I know of a midwife, unlicensed and not even a CPM, who is saving mother's and babies' lives among the Amish. Otherwise the Amish in her community will deliver their babies in the BARN if they have other children. Even the doctors in her community donated money to her to build some birth rooms in her garage so that she can help the mothers give birth in a safe place.

She will at times call to ask advice. I will continue to give advice to her!! Many doctors over the years have given advice to me when I had questions. I am still unlicensed and valued their opinions as to what options were before us. I will be forever grateful that they did not have this kind of rule that prevented them from helping others. I still feel free to call them even to this day. THIS IS A MAKE OR BREAK ISSUE FOR ME!! I WILL NOT SEEK LICENSURE IN SOUTH DAKOTA IF THIS REMAINS AS PART OF THE LICENSURE REQUIREMENTS!

Drug	Indication	Dose	Route of Administration	Duration of Treatment
Phylloquinone (Vitamin K_1)	Prophylaxis for Vitamin K deficiency bleeding	1 mg	Intramuscularly	1 dose
Oxytocin (Pitocin)	Postpartum hemorrhage only	10 Units/ml	Intramuscularly only	1-2 doses. Transport to hospital required if more than two (2) doses are administered.
Misoprostol Note: This in an appropriate off label use of this drug.	Postpartum hemorrhage only	200 microgram tabs, at 800 micrograms per dose (4 tabs)	Rectal or sublingual, or may be used as ½ rectally and ½ sublingually	1-2 doses. Transport to hospital required if more than 2 doses are administered. Not to exceed 800 micrograms.
Methylergonovine (Methergine)	Postpartum hemorrhage only	0.2 mg	Intramuscular or orally	Single dose. Every six hours, may repeat 3 times. Contraindicated in hypertension and Raynaud's Disease.
Lidocaine HCL 1% or 2%	Local anesthetic for use during postpartum repair of lacerations or episiotomy	Maximum 50 ml (1%) Maximum 15 ml (2%)	Percutaneous infiltration only	Completion of repair
Penicillin G (Recommended)	Group B Strep Prophylaxis	5 million units initial dose, then 2.5 million units every 4 hours until birth	IV in $\geq$ 100 ml LR, NS or D_5LR	Until birth of baby
Ampicillin Sodium (Alternative)	Group B Strep Prophylaxis	2 grams initial dose, then 1 gram every 4 hours until birth	IV in $\geq$ 100ml NS	Until birth of baby
Cefazolin Sodium	Group B Strep Prophylaxis	2 grams initial dose, then 1 gram every 8 hours	IV in $\geq$ 100 ml LR, NS or D_5LR	Until birth of baby
Clindamycin Phosphate	Group B Strep Prophylaxis	900 mg every 8 hours	IV in $\geq$ 100ml NS or LR	Until birth of Baby
Lactated Ringer's (LR)	To administer group B Strep Prophylaxis		Intravenous catheter	
5% Dextrose in Lactated Ringer's solution (D_5LR)	To administer group B Strep Prophylaxis		Intravenous catheter	
0.9% Sodium Chloride (NS)	To administer group B Strep Prophylaxis		Intravenous catheter	
Oxygen	Maternal/Fetal Distress, or Neonatal Resuscitation	10-12 L/min 10 L/min	Mask or bag and mask	Until stabilization is achieved or transfer to a hospital is complete
0.5% Erythromycin Ophthalmic Ointment	Prophylaxis of Neonatal Ophthalmia	1 cm ribbon in each eye	Topical	1 dose
Rh(D) Immune Globulin	Prevention of RH(D) sensitization in Rh(D) negative women	300 mcg	Intramuscularly	Single dose at any gestation for Rh(D) negative, antibody negative women within 72 hours of spontaneous bleeding or abdominal trauma. Single dose at 26-28 weeks gestation for Rh(D) negative, antibody negative women. Single dose for Rh(D) negative, antibody negative women within 72 hours of delivery of Rh(D) positive infant, or infant with unknown blood type.

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

DIRECTOR'S OFFICE

BOARD OF MIDWIFERY

Filed with the Secretary of State on

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, or 45(a)(6) of 1969 PA 306. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

(By authority conferred on the director of the department of licensing and regulatory affairs by sections 16145, 16148, and 17101 of 2016 PA 417, MCL 333.16145, MCL 333.16148, and MCL 333.17101 and Executive Reorganization Order Nos. 1991-9, 1996-2, 2003-1, and 2011-4, MCL 330.3501, 445.2001, 445.2011, and 445.2030)

R 338.17101, R 338.17111, R 338.17113, R 338.17115, R 338.17121, R 338.17123, R 338.17125, R 338.17127, R 338.17131, R 338.17132, R 338.17133, R 338.17134, R 338.17135, R 338.17136, R 338.17137, R 338.17138, and R 338.17141 are added to the Michigan Administrative Code to read as follows:

PART 1. GENERAL PROVISIONS

R 338.17101 Definitions.

Rule 101. (1) As used in these rules:

(a) "Board" means the Michigan board of licensed midwifery.

(b) "Code" means 1978 PA 368, MCL 333.1101 to 333.25211.

(c) "Department" means the Michigan department of licensing and regulatory affairs.

(d) "Peer review" means the process utilized by midwives to confidentially discuss patient cases in a professional forum, which includes support, feedback, follow-up, and learning objectives.

(2) Terms defined in the code have the same meanings when used in these rules.

PART 2. PRELICENSURE LICENSED MIDWIFERY EDUCATION

R 338.17111 Training standards for identifying victims of human trafficking: requirements.

Rule 111. (1) Pursuant to section 16148 of the code, MCL 333.16148, an individual seeking licensure or registration who is licensed or registered shall complete a one-time training in identifying victims of human trafficking that meets all the following standards:

(a) Training content shall cover all of the following:

(i) Understanding the types and venues of human trafficking in the United States.

(ii) Identifying victims of human trafficking in health care settings.

(iii) Identifying the warning signs of human trafficking in health care settings for adults and minors.

(iv) Resources for reporting suspected victims of human trafficking.

(b) Acceptable providers or methods of training include any of the following:

(i) Training offered by a nationally-recognized or state-recognized health-related organization.

(ii) Training offered by, or in conjunction with, a state or federal agency.

(iii) Training obtained in an educational program that has been approved by the board for initial license or registration, or by a college or university.

(iv) Reading an article related to the identification of victims of human trafficking that meets the requirements of subdivision (a) of this subrule and is published in a peer review journal, health care journal, or professional or scientific journal.

(c) Acceptable modalities of training may include any of the following:

(i) Teleconference or webinar.

(ii) Online presentation.

(iii) Live presentation.

(iv) Printed or electronic media.

(2) The department may select and audit a sample of individuals and request documentation of proof of completion of training. If audited by the department, an individual shall provide an acceptable proof of completion of training, including either of the following:

(a) Proof of completion certificate issued by the training provider that includes the date, provider name, name of training, and individual's name.

(b) A self-certification statement by an individual. The certification statement shall include the individual's name and either of the following:

(i) For training completed pursuant to subrule (1)(b)(i) to (iii) of this rule, the date, training provider name, and name of training.

(ii) For training completed pursuant to subrule (1)(b)(iv) of this rule, the title of the article, author, publication name of peer review journal, health care journal, or professional or scientific journal, and date, volume, and issue of publication, as applicable.

(3) Pursuant to section 16148 of the code, MCL 333.16148, the requirements specified in subrule (1) of this rule shall apply for license or registration renewals beginning with the first renewal cycle after the promulgation of this rule and for initial licenses or registrations issued 5 or more years after the promulgation of this rule.

R 338.17113 Licensed midwifery accrediting organizations.

Rule 113. (1) The board approves the midwifery education accreditation council (MEAC) as an accrediting organization.

(2) A petition may be filed with the board for approval of a midwifery accrediting organization which will be evaluated to determine the organization's equivalence to the standards of other board approved accrediting organizations.

R 338.17115 Licensed midwifery credentialing program.

Rule 115. The board may approve a licensed midwifery credentialing program if it is equivalent to the credential of certified professional midwife (CPM) from North American registry of midwives (NARM), meets the criteria of section 16148 of the code, MCL 333.16148, and is accredited by the national commission for certifying agencies (NCCA) or another accrediting organization approved by the board.

PART 3. LICENSURE

R 338.17121 Licensure.

Rule 121. (1) In addition to meeting the requirements of sections 16174 and 17115 of the code, MCL 333.16174 and MCL 333.17115, an applicant for licensure must submit a completed application on a form provided by the department, together with the requisite fee.

(2) An applicant for licensure who has not completed an educational program or pathway accredited by MEAC may petition the board to evaluate whether an educational program or pathway accredited by another accrediting organization is equivalent to a program or pathway accredited by MEAC.

(3) An applicant for licensure who does not hold the credential of CPM from NARM may petition the board to evaluate whether a credential is equivalent to the credential of CPM from NARM.

(4) The board approves and adopts the examination developed and scored by NARM.

(5) An applicant for licensure may petition the board to evaluate whether another examination meets the requirements of section 16178(1) of the code, MCL 333.16178(1).

(6) A licensed midwife shall have obtained his or her recredential or maintain his or her credential of CPM from NARM, or equivalent credential approved by the board, during the license cycle.

R 338.17123 Licensure by endorsement.

Rule 123. (1) An applicant who has never been licensed as a licensed midwife in Michigan may apply for a license by endorsement by submitting a completed application, on a form provided by the department, together with the requisite fee.

(2) In addition to meeting the requirements of sections 16174 and 17119 of the code, MCL 333.16174 and MCL 333.17119, an applicant who meets the requirements of this rule is presumed to meet the requirements of section 16186 of the code, MCL 333.16186.

(3) Pursuant to section 17119(2) of the code, MCL 333.17119(2), an applicant for licensure who does not hold the credential of CPM from NARM may petition the board to evaluate whether a credential is equivalent to the credential of CPM from NARM.

(4) Pursuant to section 17119(2) of the code, MCL 333.17119(2), an applicant for licensure may petition the board to evaluate whether another examination meets the requirements of section 16178(1) of the code, MCL 333.16178(1).

R 338.17125 Relicensure requirements.

Rule 125. An applicant for relicensure whose Michigan licensed midwifery license has lapsed, under the provisions of section 16201(3) or (4) of the code, MCL 333.16201(3) or (4), as applicable, may be relicensed by complying with the following requirements as noted by (√):

(1) For a midwife who has let his or her Michigan license lapse and who does not hold a license in another state:	Lapsed less than 3 years	Lapsed more than 3 years, but less than 7 years	Lapsed 7 or more years

(a) Application and fee: submit a completed application on a form provided by the department, together with the requisite fee.	√	√	√
(b) Good moral character: establish that he or she is of good moral character as defined under section (1) to section (7) of 1974 PA 381, MCL 338.41 to 338.47.	√	√	√
(c) Fingerprints: submit fingerprints as required under section 16174(3) of the code, MCL 333.16174(3).		√	√
(d) Continuing education: submit proof of having completed 30 hours of continuing education in courses and programs approved by the board, including at least 1 hour in pain and symptom management which was earned within the 3-year period immediately preceding the application for relicensure.	√	√	√
(e) Examination: within the 3 year period immediately preceding the application for relicensure, retake and pass the examination approved by the board pursuant to R 338.17301.			√
(f) Proof of license from another state where licensed: an applicant's license must be verified by the licensing agency of all other states of the United States in which the applicant holds a current license or ever held a license as a midwife. Verification must be sent directly to the department from the licensing agency and include the record of any disciplinary action taken or pending against the applicant.	√	√	√
(g) Credential: submit proof of an active credential of CPM from the NARM or an equivalent credential from another midwifery credentialing program that is approved by the board and accredited by the NCCA or another accrediting organization approved by the board. A licensed midwife shall maintain his or her credential of CPM from NARM, or equivalent credential approved by the board, during the license cycle.	√	√	√

(2) For a midwife who has let his or her Michigan license lapse, but who holds a current and valid	Michigan license	Michigan license	Michigan license

licensed midwife license in another state:	lapsed Less than 3 years	lapsed more than 3 years, but less than 7 years	lapsed 7 or more years
(a) Application and fee: submit a completed application on a form provided by the department, together with the requisite fee.	√	√	√
(b) Good moral character: establish that he or she is of good moral character as defined under section (1) to section (7) of 1974 PA 381, MCL 338.41 to 338.47.	√	√	√
(c) Fingerprints: submit fingerprints as required under section 16174(3) of the code, MCL 333.16174(3).		√	√
(d) Continuing education: submit proof of having completed 30 hours of continuing education in courses and programs approved by the board, including at least 1 hour in pain and symptom management which was earned within the 3-year period immediately preceding the application for relicensure.		√	√
(e) Proof of license verification from another state where licensed: an applicant's license must be verified by the licensing agency of all other states of the United States in which the applicant holds a current license or ever held a license as a midwife. Verification must be sent directly to the department from the licensing agency and include the record of any disciplinary action taken or pending against the applicant.	√	√	√
(f) Credential: submit proof of an active credential of CPM from the NARM or an equivalent credential from another midwifery credentialing program that is approved by the board and accredited by the NCCA or another accrediting organization approved by the board. A licensed midwife shall maintain his or her credential of CPM from NARM, or equivalent credential approved by the board, during the license cycle.	√	√	√

R 338.17127 English language requirement.

Rule 127. (1) An applicant who attended a nonaccredited program pursuant to R 338.17121, or a program outside of the United States, shall demonstrate a working knowledge of the English language. An applicant shall demonstrate a working knowledge of the English language by satisfying 1 of the following requirements:

(i) Submit proof that he or she has obtained a total score of not less than 80 on the test of English as a foreign language internet-based test (TOEFL-iBT) administered by the educational testing service (ETS).

(ii) Submit proof that he or she completed an educational program located in any country where English is an official language.

PART 4. PRACTICE, CONDUCT, AND CLASSIFICATION OF CONDITIONS

R 338.17131 Definitions.

Rule 131. As used in this part:

(a) "Appropriate health professional" means any individual licensed, registered or otherwise authorized to engage in a health profession under Article 15 of the Public Health Code.

(b) "Appropriate pharmacology training" means 8 hours of training related to pharmacology applicable to midwifery practice, approved by MEAC or the board.

(c) "Consultation" means the process by which a licensed midwife, who maintains primary management responsibility for the patient's care, seeks the advice of another appropriate health professional or member of the health care team.

(d) "Futility" means care offered that would not mitigate a patient's lethal diagnosis or prognosis of imminent death.

(e) "Refer" means to suggest a patient seek discussion, information, aid, or treatment from a particular appropriate health professional.

(f) "Transfer" means to convey the responsibility for the care of a patient to another appropriate health professional.

(g) "Transport" means the physical movement of a patient from 1 location to another.

R 338.17132 Informed disclosure and consent.

Rule 132. (1) At the inception of care for a patient, a licensed midwife shall do the following:

(a) Provide an informed disclosure to the patient that includes the following:

(i) A description of the licensed midwife's training, philosophy of practice, transfer of care plan, credentials and legal status, services to be provided, availability of a complaint process both with NARM and the state, and relevant Health Insurance Portability and Accountability Act (HIPAA) disclosures.

(ii) Access to the midwife's personal practice guidelines.

(iii) Whether the licensed midwife is permitted to administer drugs and medications pursuant to R 338.17137, and which medications the licensed midwife carries for potential use.

(iv) Access to the board of licensed midwifery rules.

(v) Whether the licensed midwife has malpractice liability insurance coverage, and if so, the policy limitations of the coverage. The patient must be informed of the coverage and policy limitations both verbally and in writing.

(2) If during care and shared decision making, a patient chooses to deviate from a licensed midwife's recommendation, the licensed midwife shall provide the patient with an informed consent process which must include:

(a) Explanation of the available treatments and procedures.

(b) Explanation of both the risks and expected benefits of the available treatments and procedures.

(c) Discussion of alternative procedures, including delaying or declining of testing or treatment, and the risks and benefits associated with each choice.

(d) Documentation of any initial refusal by the patient of any action, procedure, test or screening that is recommended by the licensed midwife.

(3) A licensed midwife shall obtain the patient's signature acknowledging that the patient has been informed, verbally and in writing, of the disclosures.

(4) A licensed midwife is exempt from the requirements of subrules (2) and (3) of this rule if the deviation occurs after the inception of active labor, or in an emergent situation, or if the change in the condition of a patient requires immediate action on the part of the licensed midwife.

R 338.17133 Additional informed consent requirements.

Rule 133. (1) Additional informed consent processes are required when a patient presents to a licensed midwife under any of the following circumstances:

(a) Previous cesarean birth – at the inception of care.

(b) Fetus in a breech presentation – when it is likely in the midwife's judgment the fetus will present in breech presentation at the onset of labor.

(c) Twin or multiple gestation – at the time of discovery by the midwife.

(2) The licensed midwife shall disclose to the patient his or her personal practice guidelines surrounding the management of the pregnancies listed in subrule (1) of this rule, which must include the licensed midwife's level of experience, type of special training, care philosophy, and outcome history relative to such circumstances.

(3) The disclosure must contain information regarding the licensed midwife's care team and style of management to be expected under such circumstances, including a description of conditions under which the licensed midwife shall recommend transfer or transport.

(4) The licensed midwife shall practice within the limits of his or her personal practice guidelines described in this rule.

(5) The licensed midwife shall provide the patient with an informed choice document, specific to the patient's situation, which includes the potential increased risks and benefits of:

(a) The circumstances listed in subrule (1) of this rule.

(b) Birth outside a hospital setting associated with the circumstances listed in subrule (1) of this rule.

(c) Medical care options associated with the circumstances listed in subrule (1) of this rule, including the risks of cesarean section, both in the current pregnancy and any future pregnancies.

(6) A licensed midwife is exempt from the requirements of this rule if the circumstances listed in subrule (1) of this rule are discovered after the inception of active labor, in an

emergent situation, or if the change in the condition of a patient requires immediate action on the part of the licensed midwife.

R 338.17134 Consultation and referral.

Rule 134. (1) A licensed midwife shall consult with or refer a patient to an appropriate health professional if the patient presents with the following conditions that in the judgment of the licensed midwife warrant consultation or referral:

(a) Antepartum:

(i) Gestational hypertension.

(ii) Persistent, severe headaches, epigastric pain or visual disturbances.

(iii) Persistent symptoms of urinary tract infection.

(iv) Significant vaginal bleeding before the onset of labor not associated with uncomplicated spontaneous abortion.

(v) Rupture of membranes prior to the 36.6 weeks of gestation without active labor.

(vi) Noted abnormal decrease in or cessation of fetal movement.

(vii) Hemoglobin level less than 9 and resistant to supplemental therapy.

(viii) A temperature of 100.4 degrees Fahrenheit or 38.0 degrees Celsius or greater for more than 24 hours.

(ix) Isoimmunization, Rh-negative sensitization, or any other positive antibody titer, which would have a detrimental effect on the mother or fetus.

(x) Abnormally elevated blood glucose levels unresponsive to dietary management.

(xi) Positive HIV antibody test.

(xii) TORCH (Toxoplasmosis, other, rubella, cytomegalovirus, and herpes simplex infections.)

(xiii) Symptoms of severe malnutrition, severe persistent dehydration, or protracted weight loss.

(xiv) Symptoms of deep vein thrombosis.

(xv) Documented placenta previa.

(xvi) Documented placenta overlying the site of a previous uterine scar.

(xvii) Active labor prior to 36.0 weeks of gestation.

(xviii) Fetus with diagnosed congenital abnormalities that will require immediate medical intervention at birth.

(xix) History of myomectomy.

(xx) Pelvic or uterine abnormalities affecting normal vaginal births, including tumors and malformations.

(xxi) Marked abnormal fetal heart tones.

(xxii) Abnormal non-stress test or abnormal biophysical profile.

(xxiii) Marked or severe hydramnios or oligohydramnios.

(xxiv) Suspected intrauterine growth restriction.

(xxv) Gestation beyond 42 weeks.

(xxvi) Suspected perinatal mood disorder or uncontrolled current serious psychiatric illness.

(xxvii) Suspected active alcohol use disorder.

(xxviii) Suspected active substance use disorder.

(xxix) Receiving opioid replacement therapy.

(xxx) Sexually transmitted infection.

(xxxi) Symptoms of ectopic pregnancy.

(xxxii) Second or third trimester fetal demise.
(xxxiii) Symptoms or evidence of hydatidiform mole.
(xxxiv) Thrombocytopenia with a count less than 100,000 platelets per microliter.
(xxxv) Vaginal infection unresponsive to treatment.
(xxxvi) Symptoms or clinical evidence of hepatitis.
(xxxvii) Abnormal liver or metabolic panel.
(xxxviii) Abnormal PAP test results.
(xxxix) Significant hematological disorders or coagulopathies, or pulmonary embolism.
(xxxx) Any other condition or symptom that could threaten the health of the mother or fetus, as assessed by a licensed midwife exercising reasonable skill and judgment.
(b) Intrapartum:
(i) Blood pressure exceeding 160/110.
(ii) Persistent, severe headaches, epigastric pain or visual disturbances.
(iii) Temperature over 100.4 degrees Fahrenheit or 38.0 degrees Celsius in absence of environmental factors.
(iv) Signs or symptoms of maternal infection.
(v) Confirmed ruptured membranes without onset of labor after 72 hours.
(vi) Excessive vomiting, dehydration, acidosis, or exhaustion unresponsive to treatment.
(vii) Uncontrolled current serious psychiatric illness.
(viii) Any other condition or symptom that could threaten the health of the mother or fetus, as assessed by a licensed midwife exercising reasonable skill and judgment.
(c) Postpartum:
(i) Failure to void bladder within 6 hours of birth.
(ii) Temperature of 101.0 degrees Fahrenheit or 39 degrees Celsius for more than 12 hours.
(iii) Signs or symptoms of uterine sepsis.
(iv) Symptoms of deep vein thrombosis.
(v) Suspected perinatal mood disorder or uncontrolled current serious psychiatric illness.
(vi) Suspected active alcohol use disorder.
(vii) Suspected active substance use disorder.
(viii) Lacerations requiring repair beyond the scope of practice of the licensed midwife.
(ix) Any other condition or symptom that could threaten the health of the mother as assessed by a licensed midwife exercising reasonable skill and judgment.
(d) Infant:
(i) Abnormal metabolic infant screening.
(ii) Failed hearing screening.
(iii) Jaundice occurring outside of normal range.
(iv) Failure to urinate within 36 hours of birth.
(v) Failure to pass meconium within 48 hours of birth.
(vi) Medically significant nonlethal congenital anomalies.
(vii) Suspected birth injury.
(viii) Signs of clinically significant dehydration.
(ix) Signs and symptoms of neonatal abstinence syndrome.
(x) Any other abnormal infant behavior or appearance that could adversely affect the health of the infant, as assessed by a licensed midwife exercising reasonable skill and judgment.

(2) When a referral to an appropriate health professional is made, after referral the licensed midwife may, if possible, remain in communication with the appropriate health professional until resolution of the concern.

(3) Neither consultation nor referral preclude the possibility of continued care by a licensed midwife or the possibility of an out-of-hospital birth. It is appropriate for the licensed midwife to maintain care of the patient to the greatest degree possible. The patient may elect not to accept a referral or an appropriate health professional's advice. If full informed consent has been provided, and if the refusal is documented in writing, the licensed midwife may continue or discontinue to care for the patient.

R 338.17135 Emergent transfer of care.

Rule 135. (1) In emergent circumstances a licensed midwife may transfer the care of a patient to an appropriate health professional. The following conditions require immediate notification and emergency transfer to a hospital:

(a) Mother:

(i) Seizures.

(ii) Unconsciousness.

(iii) Respiratory distress or arrest.

(iv) Maternal shock unresponsive to treatment.

(v) Symptoms of maternal stroke.

(vi) Symptoms of suspected psychosis.

(vii) Symptomatic cardiac arrhythmias or chest pain.

(viii) Prolapsed umbilical cord.

(ix) Symptoms of uterine rupture.

(x) Symptoms of placental abruption.

(xi) Symptoms of preeclampsia or eclampsia.

(xii) Severe abdominal pain inconsistent with normal labor.

(xiii) Symptoms of pulmonary or amniotic fluid embolism.

(xiv) Symptoms of chorioamnionitis that include the presence of a fever greater than 100.4 degrees Fahrenheit or 38.0 degrees Celsius and 2 of the following 3 signs: uterine tenderness, maternal or fetal tachycardia, or foul/purulent amniotic fluid.

(xv) Unresolved fetal malpresentation not compatible with spontaneous vaginal delivery.

(xvi) Hemorrhage non-responsive to therapy.

(xvii) Uterine inversion.

(xviii) Persistent uterine atony.

(xvix) Symptoms of anaphylaxis.

(xx) Failure to deliver placenta within 2 hours in the third stage.

(xxi) Persistent abnormal vital signs.

(xxii) Significant abnormal bleeding prior to delivery, with or without abdominal pain.

(xxiii) Fetal distress evidenced by abnormal fetal heart tones when birth is not imminent.

(b) Infant:

(i) Persistent cardiac irregularities.

(ii) Persistent central cyanosis, pallor, or abnormal perfusion.

(iii) Persistent lethargy or poor muscle tone.

(iv) Seizures.

(v) Apgar score of 6 or less at 5 minutes without significant improvement by 10 minutes.

(vi) Non-transient respiratory distress.
(vii) Significant signs or symptoms of infection.
(viii) Evidence of unresolved hypoglycemia.
(ix) Abnormal, bulging, or depressed fontanel.
(x) Significant evidence of prematurity.
(xi) Clinically significant abnormalities in vital signs, muscle tone, or behavior.
(xii) Failed critical congenital heart defect screening.
(xiii) Persistent inability to suck.
(xiv) Clinically significant abdominal distension.
(xv) Clinically significant projectile vomiting.

(2) The licensed midwife shall initiate immediate transport according to the licensed midwife's emergency care plan; provide necessary emergency stabilization until emergency medical services arrive or transfer is completed; provide pertinent information to the appropriate health professional; and is encouraged to fill out a patient transfer form provided by the department.

(3) Transport via private vehicle is an acceptable method of transport if it is the most expedient method for accessing medical services.

(4) A licensed midwife may continue to provide care to a patient with any of the complications or conditions set forth in this rule under the following circumstances:
(i) if no appropriate health professional or other equivalent medical services are available;
(ii) if delivery occurs during transport;
(iii) if the patient refuses to be transported to the hospital; or
(iv) if the transfer or transport entails futility, or extraordinary and unnecessary human suffering.

(5) The licensed midwife may remain in consultation with the appropriate health professional after a transfer is made.

(6) If authorized by the patient, a licensed midwife may be able to be present during the labor and childbirth, and care may return to the midwife upon discharge.

R 338.17136 Prohibited Conduct.

Rule 136. (1) An individual covered by these rules may not perform the following acts:
(a) Except as provided in R 338.17137, administer prescription drugs or medications.
(b) Use vacuum extractors or forceps.
(c) Prescribe medications.
(d) Perform surgical procedures other than episiotomies, repairs of perineal lacerations, clamping and cutting the umbilical cord, and frenulum revisions.
(e) Knowingly accept sole responsibility for prenatal or intrapartum care of a patient with any of the following risk factors:
(i) Chronic significant maternal cardiac, pulmonary, renal, or hepatic disease.
(ii) Malignant disease in an active phase.
(iii) Insulin dependent diabetes mellitus.
(iv) Active tuberculosis.
(v) Active syphilis.
(vi) Confirmed AIDS status.
(vii) Current seizure disorder requiring medication.
(viii) History of previous uterine rupture.

(ix) Monoamniotic twins.
(x) Opioid use disorder.

R 338.17137 Administration of prescription drugs or medications.
Rule 137. (1) A licensed midwife who has appropriate pharmacology training and holds a standing prescription from an appropriate health professional with prescriptive authority, may, but is not required to administer the following prescription drugs and medications.
(a) Prophylactic vitamin K to an infant, either orally or through intramuscular injection.
(b) Antihemorrhagic agents to a postpartum mother after the birth of the infant.
(c) Local anesthetic for the repair of lacerations to a mother.
(d) Oxygen to a mother or infant.
(e) Prophylactic eye agent to an infant.
(f) Prophylactic Rho(D) immunoglobulin to a mother.
(g) Agents for group B streptococcus prophylaxis, recommended by the federal centers for disease control and prevention, to a mother.
(h) Intravenous fluids, excluding blood products, to a mother.
(i) Antiemetics to the mother.
(j) Epinephrine.
(k) Nitrous oxide.
(l) Any other drug or medication authorized by the board.
(2) Administration of any of the drugs included in subrule (1) of this rule must be in accordance with this rule. The indications, dose, route of administration, duration of treatment, and contraindications relating to the administration of drugs or medications identified under subrule (1) of this rule are as follows:

(See Table)

R 338.17138 Report patient's data.
Rule 138. (1) Unless the patient refuses, a licensed midwife shall report patient data to the statistics registry maintained by midwives alliance of North America's (MANA) division of research (DOR), in accordance with MANA's policies and procedures, or a similar registry maintained by a successor organization approved by the board.
(2) A licensee must register with MANA's DOR.
(3) Annually, by the date determined by MANA, a licensee must submit patient data on all completed courses of care in the licensee's practice during the previous twelve months.

(4) During the first year of licensure, a licensee must submit data from the date of licensure to the date determined by MANA.

PART 5. LICENSE RENEWAL AND CONTINUING EDUCATION

R 338.17141 License renewals; requirements; applicability.

Rule 141. (1) In addition to meeting the requirements of section 16201 of the code, MCL 333.16201, an applicant for renewal shall submit a completed application on a form provided by the department, together with the requisite fee and, prior to renewal, shall hold the credential of CPM from NARM, or equivalent credential approved by the board.

(2) Pursuant to section 16201 of the code, MCL 333.16201, an applicant for license renewal who has been licensed for the 4 year period immediately prior to renewal, shall accumulate all of the following, during the prior 4 years and before renewal:

(a) At least 30 hours of continuing education that is met by obtaining and maintaining, the credential of CPM from NARM, or an equivalent credential approved by the board.

(b) One hour of continuing education in pain and symptom management pursuant to section 16204(2) of the code, MCL 333.16204(2). Acceptable methods of continuing education in pain and symptom management includes online and in person presentations, courses or programs and may include, but is not limited to, the following subject areas: behavior management, psychology of pain, behavior modification, stress management, and clinical applications as they relate to professional practice.

(c) Two hours of continuing education on cultural awareness that include examination of disparate maternal infant mortality and morbidity experienced by the African American and indigenous populations. Acceptable methods of continuing education in cultural awareness includes online and in person presentations, courses, programs, or reading an article that is published in a peer review journal, health care journal, or professional or scientific journal.

(3) "Continuing education hour" means the cumulative number of program minutes divided by 60. When the fractional part of an hour is 55 minutes or more, it counts as 1 hour. Any portion of an hour between 30 and 54 minutes counts as half of an hour. Any part of an hour less than 30 minutes will be discarded. Breaks are not counted.

(4) Submission of an application for renewal constitutes the applicant’s certification of compliance with the requirements of this rule.

(5) A licensee shall retain documentation of meeting the requirements of this rule for a period of 4 years from the date of applying for license renewal.

(6) The board may require an applicant or licensee to submit evidence to demonstrate compliance with this rule.

(7) A self-certification statement by an individual which includes the title of the article, author, publication name, date, volume, and issue of publication, as applicable, is acceptable evidence of reading an article that is published in a peer review journal, health care journal, or professional or scientific journal.

(8) Failure to comply with this rule is a violation of section 16221(h) of the code, MCL 333.16221(h).

(9) A request for a waiver under section 16205 of the code, MCL 333.16205, must be received by the department prior to the expiration date of the license. A CPM credential from NARM, or equivalent credential approved by the board, may not be waived.

(10) The requirements of this part do not apply to an applicant during an initial licensure cycle.

Administration of Prescription Drugs and Medications

Medication	*Indication*	*Dose*	*Route of Administration*	*Duration of Treatment*	*Contraindications*	*Comments*
Oxygen	Maternal: fetal distress, maternal shock, stroke-like symptoms. Neonatal: neonatal resuscitation, if indicated; abnormal pulse oximetry readings.	Maternal: 12L/minute. Neonatal: 10L/minute, or as indicated.	Maternal: free-flow, nasal cannula, mask. Neonatal: bag and mask, free-flow.	Maternal: until stablized or transfer of care. Neonatal: until pulse-oximetry readings are within target range of infant age, or transfer of care.	None, with indications present.	Administration of oxygen to a neonate should be in accordance with NRP standards. When an oxygen blender is not accessible, free-flow oxygen may be used combined with pulse oximetry. Current research cautions that inappropriate use of oxygen can cause free radical and oxidative stress damage in the neonate.
0.5% Erythromycin Opthalmic ointment	Prophylaxis of neonatal ophthalmia neonatorum due to N. gonorrhoeae or C. trachomatis.	1 cm ribbon of 0.5% ointment in each eye within 24 hours of birth.	Ocular, in lower eyelid.	1 dose.	Hypersensitivity to drug class or component.	May cause ocular irritation or blurred vision.
Pitocin 10 units/ml	Prevention and treatment of postpartum hemorrhage.	10 units/ml.	Intramuscular.	1-2 doses, PRN.		
Pitocin 10 units/ml	Prevention and treatment of postpartum hemorrhage.	20 units in 1000 ml IV fluids, Initial bolus rate 1000 ml/hour bolus for 30 minutes (equals 10 units) followed by a maintenance rate 125 ml/hour over 3.5 hours (equals remaining 10 units).	Intravenous.	4 hours.		
Methyl-ergonovine (Methergine) 0.2 mg/ml	Prevention and treatment of postpartum hemorrhage.	0.2 mg/ml.	Intramuscular.	0.2 mg IM q2-4hr PRN; not to exceed 5 doses.	Contraindicated for patient with hypertension or Reynaud's disease. Can be used in conjunction with Pitocin after delivery of the placenta.	IM preferred for acute postpartum use. Oral methergine can help to lessen continued bleeding after hemorrhage.
Methyl-ergonovine (Methergine) 0.2 mg		0.2 mg tab.	Oral.	0.2-0.4 mg PO q6-8hr PRN for 2-7 days .	Contraindicated for patient with hypertension or Reynaud's disease.	IM preferred for acute postpartum use. Oral methergine can help to lessen continued bleeding after hemorrhage.
Vitamin K 1.0 mg/0.5 ml	Prophylaxis and therapy of hemorrhagic disease of the newborn.	0.5-1.0 mg.	Intramuscular.	Single dose.	Family history of hypoprothrombinaemia; hypersensitivity to drug class or component.	
Misoprostol (Cytotec)	Postpartum hemorrhage.	600mg oral or 800 mg buccal or rectal.	Oral, buccal, rectal.	Single dose.		
RHo (D) Immune Globulin (Rhogam)	Prophylactic dose: RH- patient at 28-30 weeks gestation; RH- patient after a miscarriage; postpartum RH- patient with an RH+ baby. A prenatal dose can also be given after an injury under advisement of a physician.	300 mcg. pre-filled syringe.	Intramuscular.	Administer within 72 hours of birth or antenatal event.	RH positive; IgA deficiency.	
Penicillin G	Group Beta Strep (GBS) prophylaxis in labor.	Initial loading dose: 5 million units IV. Subsequent doses: 2.5–3.0 million units IV every 4 hours.	Administer via IVPB with prepared minibag.	Until delivery.	Allergy to penicillin.	
Ampicillin	Group Beta Strep prophylaxis in labor.	Initial loading dose: 2 g IV. Subsequent doses: 1 g IV every 4 hours.	Administer via IVPB with prepared minibag.	Until delivery.	Allergy to penicillin.	

Cefazolin	Group Beta Strep prophylaxis in labor.	Initial loading dose: 2g IV. Subsequent doses: 1g IV every 8 hours.	Administer via IVPB with prepared minibag.	Until delivery.	Allergy to cefazolin.	Cefazolin is the first choice for patient who have a history of allergy to penicillin but no history of anaphylactic reaction to penicillin. Use clindomycin or vancomycin for patients who have a history of anaphylactic penicillin allergy.
Clindamycin	Group Beta Strep prophylaxis in labor.	900 mg IV every 8 hours until delivery.	Administer via IVPB with prepared minibag.	Until delivery.	Allergy to clindamycin.	Use only with history of anaphylactic reaction to penicillin. Clindamycin and Vancomycin are the drugs of choice for GBS prophylaxis for patients who have a history of anaphylactic reactions to penicillin.
Vancomycin	Group Beta Strep prophylaxis in labor.	1 g IV every 12 hours.	Administer via IVPB with prepared minibag.	Until delivery.	Allergy to vancomycin.	Use only with history of anaphylactic reaction to penicillin. Clindamycin and Vancomycin are the drugs of choice for GBS prophylaxis for patients who have a history of anaphylactic reactions to penicillin.
Lactated Ringers Solution	Dehydration during labor.	Up to 2L.	Intravenous.	Over the course of 3-5 hours.		Most patients respond to intravenous hydration and a short period of gut rest, followed by reintroduction of oral intake. Preferred over normal saline.
0.9% Normal Saline solution	Dehydration during labor, when LR not available. Postpartum hemorrhage. Allergic reactions.	1L- 2L bolus.	Intravenous.	During course of infusion.		Intrapartum: the addition of 5% Dextrose to solution can increase success rate with nausea or vomiting.
Lidocaine	Postpartum repair of vulvo-vaginal lacerations.	Injectable: up to 5 ml 2%, 10 ml 1%, or 20 ml 0.5%. Topical cream, spray, or gel.	Injection.	2 hours.	Known allergy or signs or symptoms of allergic reaction.	Do not use lidocaine with epinepherine, max dose 3 mg/kg.
Antiemetic ranitidine zantac	To reduce vomiting during labor.	150 mg every 6 hours.	Oral.	Treat until symptoms subside.		
Diphenhydramine	To reduce vomiting during labor.	25 to 50 mg every 4 to 6 hours / 10-50 mg every 4-6 hours.	Oral; intravenous.			
Ondansetron	To reduce vomiting during labor.	4-8 mg IVP / 4 mg (up to twice PRN).	Oral; intravenous.			May produce headache as side effect.
Epinephrine	Severe allergic reaction.	Single dose of 0.3 mg, USP, 1:1000 (0.3 mL) in a sterile solution.		5-15 minutes. Transport to hospital should be initiated.		Discontinue medication that is causing reaction; place patient supine and elevate lower extremities. Protect the airway. Transport to hospital should follow.
Epinephrine	Neonatal resuscitation.	0.1 - 0.3 mL/kg (0.01 - 0.03 mg/kg) of body weight in a 1:10,000 concentration.	Administered in the umbilical venous catheter followed by 1 - 3 mL flush of sterile normal saline.	Repeat every 3-5 min if HR <60 bpm with chest compressions.		EMS services should be en route.
Epinephrine		1 ml/kg 1:10,000 concentration.	Endotracheal.	Repeat every 3-5 min if HR <60bpm with chest compressions.		Max 3 ml/dose, EMS services should be en route.