



**LICENSURE APPLICATION  
for  
MIDWIFE APPRENTICES  
  
REGULATION 60-24**

**Return all documentation to:**

Email address (preferred method):

[LMW@dph.sc.gov](mailto:LMW@dph.sc.gov)

OR

Mailing address:

**Bureau of Health Facilities Licensing  
P.O. Box 2046  
West Columbia, SC 29171**

For additional questions, contact us at: 803-545-4370.

## INSTRUCTIONS FOR COMPLETING THE APPLICATION

**NOTICE:** Your license must be renewed prior to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or capacity increases/decreases) from the Department that are in progress at the time the license is due for renewal.

Application must be complete and legible. Any missing information may result in delays in processing this application. Any section that requires additional space or documentation shall be included as an attachment in the 8.5" x 11" format and be labeled to identify the appropriate section. Proof of payment is required for all applications submitted.

### Reason for the Application

- Initial: Check this box only if this is the first time you are applying for a license with the Department.
- Renewal: Check this box only if you are renewing your license. Enter the license number and expiration date.
- Amended License Request: Check this box if you are applying for a change that will alter the information on the face of your license; then, ensure that you complete Part B & C.

### Part A: Applicant Information

- Please complete this section for the applicant.

### Part B: Licensure Changes

- Please complete this section for any changes.

### Part C: Verification

- You must have this page notarized.



## Application for Licensure for Midwife Apprentice Regulation 60-24

Reason for Application		
<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change Request (Complete Part B and C)
Permit Number:		Expiration Date:

Part A. Applicant Information			
Applicant's Name:			
Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Physical Address:			
City:	State:	Zip:	County:
Business Telephone Number:		Fax Number:	
Email address:			
Mailing Address (if different from above):			
City:	State:	Zip:	County:
Apprentice Supervisor Name:			

Are you able to read and write English? <input type="checkbox"/> yes <input type="checkbox"/> no		
Have you ever been licensed/certified as a midwife under a different name? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what name:		
Have you ever held a license or been certified as a midwife or an apprentice in another state? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, attach a copy of the license(s) or certification		
Have you ever had a midwife or apprentice license suspended or revoked? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, describe the cause, conditions, and length of time:		
Have you ever been convicted of any criminal offense other than a minor traffic violation? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please provide the following:		
Date of conviction:	Type of offense:	Name/Location of court:

Required documentation to be submitted:

INITIALS	RENEWALS
<input type="checkbox"/> Written verification of apprentice/supervisor relationship from the person(s) supervising the applicant.	<input type="checkbox"/> Written verification of apprentice/supervisor relationship from the person(s) supervising the applicant.
<input type="checkbox"/> Evidence of an approved course of education or a planned course of education	
<input type="checkbox"/> Evidence of negative two-step testing for TB	

**Part B: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES****(CONTACT INFORMATION)***PRIOR TO CHANGE***Current** License Number:**Current** Name:**Current** Address:

City: State: Zip: County:

Telephone Number: Fax Number:

*AFTER CHANGE***New** Name:**New** Address:

City: State: Zip: County:

**New** Mailing Address (if different from above):

City: State: Zip: County:

New Telephone Number: Fax Number:

**Part C: Verification**

State of:

County of:

I, the undersigned, do hereby swear or affirm, depose and say that I have read the foregoing application and know the contents thereof, and that the statements made therein are true and correct to the best of my knowledge.

Signature:

Print Name:

Date:

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

(Month) (Year)

**NOTARY PUBLIC** \_\_\_\_\_

My commission expires \_\_\_\_\_ **NOTARY SEAL**