LICENSURE APPLICATION
for
LICENSED MIDWIVES

REGULATION 61-24

Return all documentation to:

Email address (preferred method):
LMW@dph.sc.gov

OR

Mailing address:
Bureau of Health Facilities Licensing
2100 Bull Street
Columbia, SC 29201

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

0252-ENG-DPH (07/2024)

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.

SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Application for Licensure for Midwives
Regulation 61-24

Reason for Application			
☐ Initial	☐ Renewal		☐ Change Request (Complete Part B and C)
	Permit Number:	Expiration Date:	

Part A. Applicant Information			
Applicant's Name:			
Date of Birth:		Sex: ☐ Male ☐ Female	
Physical Address:			
City:	State:	Zip:	County:
Business Telephone Number:		Fax Number:	
Email address:			
Mailing Address (if different from above):			
City:	State:	Zip:	County:

Have you ever been licensed/certified as a midwife under a different name? ☐ yes ☐ no If yes, what name:		
Have you ever held a license or been certified as a midwife or an apprentice in another state? ☐yes ☐no If yes, attach a copy of the license(s) or certification		
Have you ever had a midwife license suspended or revoked? ☐ yes ☐ 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? ☐ yes ☐ no If yes, please provide the following:		
Date of conviction:	Type of offense:	Name/Location of court:

Required documentation to be submitted:

INITIALS	RENEWALS
☐ NARM certification ☐ Evidence of completion of educational program to be evaluated by NARM ☐ Evidence of completed apprenticeship ☐ Recommendation by supervising person ☐ CPR certification of adults and newborns ☐ Evidence of negative two-step testing for TB	☐ NARM certification ☐ 30 hours of approved continuing education ☐ CPR certification of adults and newborns ☐ Annual peer review ☐ Annual negative skin test for tuberculosis (TB)

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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 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**