

ARKANSAS DEPARTMENT OF HEALTH
Women's Health
Midwife License Renewal

Last Name	First	Middle	Date of Birth	Gender o Male o Female	Date
<i>It is your responsibility to notify us of any change in name or address</i>		Midwife License Number	Social Security Number		
Address (include Street, City, State, Zip)				Home Phone ()	
				Business Phone ()	
Mailing Address, if different from above				Other Phone (pager, etc.) ()	
College/Vocational Training/ Continuing Education since last application (attach copy of diploma/certificate)	Name and Address (City/State) of School or Provider of Continuing Education	Dates Attended		Total Credits/ Clock Hours/ Contact Hours	Date of Diploma Or Certificate
		From	To		
		From	To		
		From	To		
		From	To		
		From	To		
		From	To		
Other Licenses Now Current Name of Trade or Profession		State	License Number		Expiration Date
Have you ever had a license revoked in any health-related field? o Yes o No If yes, specify _____ _____ _____			Have you ever been convicted of a felony? o Yes o No If yes, specify _____ _____ _____		
INSTRUCTIONS					
Type or print the application and review thoroughly before submitting. An incomplete application will delay processing. The following documentation must be included with the application:					
1. Copy of certificate in Cardio-Pulmonary Resuscitation (infant and adult) showing expiration dates.					
2. Current documentation of a negative TB skin test, negative chest x-ray or a valid health card.					
3. Documentation of hours of continuing education obtained (LMW Reg. 301.02)					
Mail all forms and attachments to:					
FREEWAY MEDICAL BUILDING AR DEPT OF HEALTH, WOMEN'S HEALTH 5800 WEST 10 TH , SUITE 401, SLOT #16 LITTLE ROCK, AR 72204					