

STATE OF MARYLAND



MARYLAND BOARD OF NURSING
4140 PATTERSON AVENUE
BALTIMORE, MARYLAND 21215-2254

(410) 585-1900 FAX (410) 358-3530
(410) 585-1978 AUTOMATED VERIFICATION
1-888-202-9861 TOLL FREE

**GENERAL INSTRUCTIONS
NURSE-MIDWIFE WRITTEN AGREEMENT**

In accordance with Regulations, before a nurse-midwife may practice, the nurse-midwife shall enter into a written agreement with a physician concerning the performance by the nurse- midwife of the functions authorized by the regulations. (COMAR 10.27.05).

Each person entering into an agreement must provide a dated original signature on that agreement before submitting it to the Board of Nursing for review. The Joint Committee on Nurse-Midwives reviews written agreements, at their quarterly meeting. The Joint Committee is composed of an equal number of members appointed by the Nursing and Physicians Boards. The committee forwards their recommendations to the Board of Nursing for approval. The Board of Nursing reviews the recommendations of the Joint Committee on the fourth Tuesday of each month.

The Board will notify the nurse-midwife by mail when the written agreement has been approved. If the agreement is not approved, it will be returned or the nurse-midwife will receive a written request for additional information or clarification. It is suggested that you check www.mbp.state.md.us for physician status.

Agreement Instructions: the written agreement may be typed, printed or hand written in ink. The information must be **HIGHLY LEGIBLE** or it will be returned. Additional pages may be used when it is necessary to provide additional detail. This written agreement form may also be printed from the Board's web site: www.mbon.org.

ALWAYS include proof of training for procedures with each written agreement submitted. Fax or mail a copy of your CDS and DEA license to the Board.

SIGNATURES:

Hospital settings (inpatient or outpatient) -The CNM and the Chief of Service

Non-hospital settings (HMO, industry, health dept.) -

- a. The CNM and a designated Chief of Service/Medical Director
- b. The CNM and a physician.

Private practice

- a. Settings with one physician and one CNM - **both must sign**.
- b. Settings with more than one physician and/or one or more CNM - **all must sign**.

The facility or practice area may have their own policies regarding signatures in addition to the above requirements.

<p>THE BOARD MAY NOT APPROVE YOUR AGREEMENT FOR ANY OF THE FOLLOWING REASONS:</p> <ol style="list-style-type: none">1. FAILURE TO USE AND COMPLETE THE APPROPRIATE FORM PROVIDED BY THE BOARD.2. FAILURE TO SUBMIT DOCUMENTATION SIGNED BY THE COLLABORATOR/TRAINER FOR EDUCATION, TRAINING AND COMPETENCY.

NAME

NURSE-MIDWIFE WRITTEN AGREEMENT

**PLEASE CHECK ONE OF THE FOLLOWING.
YOU MUST ATTACH THIS PAGE TO YOUR AGREEMENT OR ADDENDUM.**

- New agreement**
- Revised agreement- state the reason for the revision**
- Addition of physician or change in physician collaborators to a previously approved agreement at the same practice or organization.
ONLY SUBMIT SECTION I. PARTS 1-A, 1-B, & 1-C. AND SECTION V.**
- Change in practice site only. Same physicians, same organization, same job description
ONLY SUBMIT SECTION I-A, SECTION 1-B, AND SECTION 1-C**
- COMPETENCY FORMS FOR NEW PROCEDURES MUST BE SIGNED BY THE COLLABORATING PHYSICIAN OR THE ORIGINAL PRECEPTOR.**

MOST COMMON REASONS FOR AGREEMENT DENIAL ARE OFTEN:

1. **Failure to use and complete the appropriate form provided by the Board.**
2. **Failure to attach documentation of current CPR, ACLS, PALS, or NRP**
3. **Failure to provide documentation of education, training and competency with sign off by the collaborator or preceptor (preceptor may be nurse practitioner, physician or midwife for OB/GYN).**

**COMPETENCY FORMS MUST BE SENT IN WITH EACH NEW AGREEMENT
EVEN IF THE PROCEDURE HAS BEEN PREVIOUSLY APPROVED.**



NURSE-MIDWIFE AGREEMENT

The purpose of this written agreement is to reflect the understanding that has been developed and the relationship that exists between the nurse-midwife and the physician consultant. ***If a nurse-midwife has arranged for consultation with more than one physician or physician group in a different practice setting, a separate written agreement is required for each individual or group.***

/	GENERAL INFORMATION: (PLEASE PRINT OR TYPE)	PAGE 2 OF 13
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A	NURSE-MIDWIFE			
	MD RN LICENSE #			
	HOME/MAILING ADDRESS			
	OFFICE ADDRESS			
	E-MAIL ADDRESS			
	HOME PHONE			
	OFFICE PHONE			
	AMERICAN MIDWIFERY CERTIFICATION BOARD CERTIFICATION # (FORMERLY KNOWN AS THE A.C.N.M.)			
	ORIGINAL DATE CERTIFIED			
	CCA CYCLE CARD EXPIRATION			
	ACNM CERTIFICATE EXPIRATION			
DEA#		ATTACH COPY OF LICENSE	<input type="checkbox"/> CDS PENDING	WHEN ISSUED, SEND COPY TO THE BOARD.
CDS#			<input type="checkbox"/> DEA PENDING	

B	LICENSED PHYSICIAN # 1	NAME	
	MD. LICENSE #.		
	SITE NAME		
	SITE ADDRESS		
	TELEPHONE		
PHYSICIAN # 1 AREAS OF SPECIALIZATION		BOARD CERTIFICATION?	
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
HOSPITAL PRIVILEGES?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
LOCATIONS	①		
	②		
	③		

	LICENSED PHYSICIAN # 2	NAME	
	MD. LICENSE #.		
	SITE NAME		
	SITE ADDRESS		
	TELEPHONE		
PHYSICIAN # 2 AREAS OF SPECIALIZATION		BOARD CERTIFICATION?	
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
HOSPITAL PRIVILEGES?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
LOCATIONS	①		
	②		
	③		

LICENSED PHYSICIAN # 3		NAME	
MD. LICENSE #.			
SITE NAME			
SITE ADDRESS			
TELEPHONE			
PHYSICIAN # 3 AREAS OF SPECIALIZATION		BOARD CERTIFICATION?	
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
HOSPITAL PRIVILEGES?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
LOCATIONS	①		
	②		
	③		
LICENSED PHYSICIAN # 4		NAME	
MD. LICENSE #.			
SITE NAME			
SITE ADDRESS			
TELEPHONE			
PHYSICIAN # 4 AREAS OF SPECIALIZATION		BOARD CERTIFICATION?	
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
HOSPITAL PRIVILEGES?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
LOCATIONS	①		
	②		
	③		

LICENSED PHYSICIAN # 5		NAME	
MD. LICENSE #.			
SITE NAME			
SITE ADDRESS			
TELEPHONE			
PHYSICIAN # 5 AREAS OF SPECIALIZATION		BOARD CERTIFICATION?	
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
HOSPITAL PRIVILEGES?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
LOCATIONS	①		
	②		
	③		

LICENSED PHYSICIAN # 6		NAME	
MD. LICENSE #.			
SITE NAME			
SITE ADDRESS			
TELEPHONE			
PHYSICIAN # 6 AREAS OF SPECIALIZATION		BOARD CERTIFICATION?	
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
		<input type="checkbox"/> YES	<input type="checkbox"/> NO
HOSPITAL PRIVILEGES?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
LOCATIONS	①		
	②		
	③		

LIST THE NAMES OF OTHER NURSE-MIDWIVES PRACTICING UNDER THE SAME WRITTEN AGREEMENT:

_____	_____
_____	_____
_____	_____

C DESCRIPTION OF PRACTICE OF NURSE-MIDWIFE, CHECK APPROPRIATE AREA

ANTEPARTUM

NAME	_____		
ADDRESS	_____		
	STREET		
	CITY	STATE	ZIP CODE

INTRAPARTUM

a.

HOSPITAL

NAME

ADDRESS

CITY

STATE

ZIP CODE

b.

BIRTH CENTER

NAME

ADDRESS

CITY

STATE

ZIP CODE

C.

HOME BIRTH

NAME

ADDRESS

CITY

STATE

ZIP CODE

d.

OTHER

NAME

ADDRESS

CITY

STATE

ZIP CODE

POSTPARTUM

NAME

ADDRESS

STREET

CITY

STATE

ZIP CODE

FAMILY PLANNING

NAME

ADDRESS

STREET

CITY

STATE

ZIP CODE

WELL WOMAN HEALTH CARE

NAME

ADDRESS

STREET

CITY

STATE

ZIP CODE

DIAGNOSIS AND TREATMENT OF STD IN MALE CLIENTS *

NAME			
ADDRESS			
	STREET		
	CITY	STATE	ZIP CODE

YOU MUST PROVIDE PROOF OF COMPLETION OF STD COURSE OFFERED BY BALTIMORE CITY HEALTH DEPARTMENT OR AN EQUIVALENT COURSE APPROVED BY THE CDC.

OTHER

NAME			
ADDRESS			
	STREET		
	CITY	STATE	ZIP CODE

D

PROCEDURES TO BE PERFORMED

YOU MUST PROVIDE PROOF OF EDUCATION, TRAINING, COMPETENCY AND SUPERVISED PERFORMANCE BEFORE SUBMITTING FOR INCLUSION IN YOUR AGREEMENT. YOU MAY USE THE COMPETENCY CHECKLIST PROVIDED (ADDENDUM) OR ANOTHER WRITTEN FORMAT.

ADDITIONS OR DELETIONS TO THIS SECTION OF THE AGREEMENT REQUIRES BOARD NOTIFICATION

- NORPLANT /CONTRACEPTIVE ROD INSERTION/REMOVAL
- COLPOSCOPIES
- SONOGRAPHY
- INSEMINATIONS
- FIRST ASSIST AT C-SECTIONS
- SCALP PH
- ENDOMETRIAL BIOPSIES
- CRYOTHERAPY
- VACUUM EXTRACTIONS
- OTHER
- CIRCUMCISION



NURSE-MIDWIFE - PHYSICIAN RELATIONSHIP

A. MUTUAL RESPONSIBILITY

- 1. THE PHYSICIAN OR DESIGNEE AGREES TO BE AVAILABLE TO THE CERTIFIED NURSE-MIDWIFE FOR CONSULTATION, COLLABORATION, AND REFERRAL AT ALL TIMES.**
- 2. THE CERTIFIED NURSE-MIDWIFE AGREES TO PRACTICE WITHIN THE SCOPE OF THE STANDARDS AND CORE COMPETENCIES ESTABLISHED BY THE AMERICAN COLLEGE OF NURSE-MIDWIVES AND IN ACCORDANCE WITH THE RULES AND REGULATIONS OF THE STATE OF MARYLAND.**
- 3. PRIOR TO SIGNING THIS AGREEMENT THE CERTIFIED NURSE-MIDWIFE AND PHYSICIAN WILL HAVE ESTABLISHED WRITTEN PROTOCOLS. THESE PROTOCOLS WILL BE SIGNED AND AVAILABLE FOR INSPECTION IN ACCORDANCE WITH SECTION .07 OF THE RULES AND REGULATIONS GOVERNING THE PRACTICE OF NURSE-MIDWIVES.**

B. CRITERIA OF "NORMALCY"

THE CERTIFIED NURSE-MIDWIFE AND PHYSICIAN CONSULTANT HAVE ESTABLISHED CRITERIA OF NORMALCY APPROPRIATE TO THE PRACTICE SETTING. THESE CRITERIA ARE INCLUDED IN THE SIGNED GUIDELINES.



NURSE-MIDWIFE FUNCTIONS

A. PROCEDURES AND MEDICATIONS

- 1. THE CERTIFIED NURSE-MIDWIFE WILL DETERMINE THE CLIENT'S STATUS BY PERFORMING A PHYSICAL ASSESSMENT, TAKING A HISTORY AND EVALUATING PSYCHOSOCIAL STATE. THE CERTIFIED NURSE-MIDWIFE WILL ORDER DIAGNOSTIC STUDIES AS SPECIFIED IN THE PROTOCOLS. WHEN THE CLIENT'S STATUS DEVIATES FROM NORMAL, THE CNM MAY ORDER ADDITIONAL DIAGNOSTIC STUDIES IN ACCORDANCE WITH ESTABLISHED PROTOCOLS AND/OR WITH PHYSICIAN CONSULTATION.**

2.

NURSE-MIDWIFE FORMULARY

CHECK THOSE CATEGORIES OF SUBSTANCES
YOU WILL PRESCRIBE OR DISPENSE IN THIS PRACTICE.

- | | | | |
|--------------------------|------------------------------------|--------------------------|--|
| <input type="checkbox"/> | ANALGESICS/NARCOID AND OPIOID | <input type="checkbox"/> | ANTIBIOTIC POTENTIATOR |
| <input type="checkbox"/> | ANALGESICS/NON-NARCOTIC AND NSAIDS | <input type="checkbox"/> | ANTICOAGULANT |
| <input type="checkbox"/> | ANESTHETICS, LOCAL | <input type="checkbox"/> | ANTIDIARRHEAL |
| <input type="checkbox"/> | ANTIANSXIETY AGENTS | <input type="checkbox"/> | ANTIEMETIC |
| <input type="checkbox"/> | ANTIBACTERIAL | <input type="checkbox"/> | IMMUNIZATIONS/BIOLOGICALS |
| <input type="checkbox"/> | ANTIBIOTICS | <input type="checkbox"/> | INTRAVENOUS FLUIDS AND ELECTROLYTES |
| <input type="checkbox"/> | ANTI-FUNGAL | <input type="checkbox"/> | LAXATIVES |
| <input type="checkbox"/> | ANTHELMINITIC | <input type="checkbox"/> | MAGNESIUM SULFATE |
| <input type="checkbox"/> | ANTIHISTAMINE | <input type="checkbox"/> | NARCOTIC POTENTIATORS |
| <input type="checkbox"/> | ANTI-INFLAMMATORIE | <input type="checkbox"/> | NASAL DRUGS/VASOCONSTRICTORS |
| <input type="checkbox"/> | ANTINAUSEANT | <input type="checkbox"/> | OPHTHALMIC OINTMENT/NEONATAL |
| <input type="checkbox"/> | ANTITUBERCULAR | <input type="checkbox"/> | OPHTHALMIC, OTIC ANTI-INFECTIVES, AND
ANTI-INFLAMMATORIES |
| <input type="checkbox"/> | ANTITUSSIVES & EXPECTORANT | <input type="checkbox"/> | OXYTOCIC |
| <input type="checkbox"/> | ANTI-ULCER DRUG | <input type="checkbox"/> | PEDICULOCIDE AND SCABICIDE |
| <input type="checkbox"/> | ANTIVIRAL | <input type="checkbox"/> | RHOGAM |
| <input type="checkbox"/> | CALCIUM GLUCONATE | <input type="checkbox"/> | SILVER NITRATE DROPS |
| <input type="checkbox"/> | CONTRACEPTIVES | <input type="checkbox"/> | SMOKING CESSATION DRUGS |
| <input type="checkbox"/> | CORTICOSTEROIDS | <input type="checkbox"/> | STEROIDS-TOPICAL |
| <input type="checkbox"/> | DECONGESTANTS | <input type="checkbox"/> | TOCOLYTIC AGENTS |
| <input type="checkbox"/> | DERMATOLOGIC PREPARATIONS | <input type="checkbox"/> | VAGINAL CREAMS |
| <input type="checkbox"/> | EPINEPHRINE | <input type="checkbox"/> | VITAMINS AND MINERALS |
| <input type="checkbox"/> | GASTROINTESTINAL | <input type="checkbox"/> | |
| <input type="checkbox"/> | HEMATINICS | <input type="checkbox"/> | |
| <input type="checkbox"/> | HEMORRHOIDAL PREPARATIONS | <input type="checkbox"/> | |
| <input type="checkbox"/> | HORMONAL DRUGS AND PREPARATIONS | <input type="checkbox"/> | |
| <input type="checkbox"/> | HYPNOTIC/SEDATIVES | <input type="checkbox"/> | |

**CATEGORIES OF DRUGS THAT WILL BE PRESCRIBED
AS PART OF CO-MANAGEMENT WITH A PHYSICIAN:**

- BRONCHO DILATORS
- ANTIHYPERTENSIVES
- ANTIDEPRESSANTS
- OTHER (SPECIFY EACH CATEGORY OF DRUG)

DRUGS RESTRICTED FOR USE IN AUTHORIZED DRUG WITHDRAWAL PROGRAMS:

- CLONIDINE
- METHADONE

NAME OF FACILITY OR PROGRAM

ADDRESS OF FACILITY OR PROGRAM

CITY, STATE AND ZIP CODE

B. TRANSPORT OF MOTHER OR NEONATE

FOR THOSE PRACTICE SETTINGS OUTSIDE OF HOSPITALS, THE CERTIFIED NURSE-MIDWIFE AND PHYSICIAN HAVE ESTABLISHED A MECHANISM FOR TRANSPORT OF MOTHERS AND BABIES WHO DEVIATE FROM NORMAL AS DEFINED IN THEIR WRITTEN PROTOCOL.

C. BIRTH CERTIFICATE

THE CERTIFIED NURSE-MIDWIFE WHO PERFORMS DELIVERIES COMPLETES AND FILES THE BIRTH CERTIFICATE AS PRESCRIBED UNDER THE STATE LAW.

D. CONSULTATION AND REFERRAL

THE CERTIFIED NURSE-MIDWIFE INITIATES FOR HER CLIENTS CONSULTATION AND REFERRAL AS NEEDED, FOR EXAMPLE: DENTAL, NUTRITIONAL.

E. INSTITUTION OF EMERGENCY PROCEDURES

THE CERTIFIED NURSE-MIDWIFE INSTITUTES EMERGENCY PROCEDURES ACCORDING TO THE PROTOCOL ESTABLISHED WITH HER BACK UP PHYSICIAN.

IV ADDITIONAL INFORMATION

(ADDITIONAL INFORMATION RE: HOME BIRTH USE BACK OF PAGE IF NECESSARY)

V**AUTHORIZATION**

THE CERTIFIED NURSE-MIDWIFE AND THE PHYSICIAN SHALL EACH ADVISE THE BOARD OF NURSING WITHIN TEN DAYS IF THEIR WRITTEN AGREEMENT IS TERMINATED OR MODIFIED. UPON TERMINATION OF A WRITTEN AGREEMENT A NURSE-MIDWIFE SHALL NOT PRACTICE NURSE-MIDWIFERY UNTIL A NEW WRITTEN AGREEMENT IS FILED WITH THE NURSING BOARD. (AUTHORITY: COMAR 10.27.07).

SIGNATURE AND DATE OF SIGNATURES SHALL BE AFFIXED BY ALL PARTIES ENTERING INTO THIS AGREEMENT.

Nurse-Midwife

SIGNATURE AND DATE

PRINT NAME

Revised: 7-06-92
 Revised: 3-31-95
 Approved by the Maryland Board of Nursing 7/25/95
 Revised 9/24/98
 Approved by the Maryland Board of Nursing 11/24/98
 Revised: 1/2002
 Revised 1/9/2002
 Approved by the Maryland Board of Nursing 02/26/02
 Revised 7/10/2002
 Revised 10/7/2002
 Revised 10/28/2003
 Revised 3/10/2004
 Revised 9/28/2005

Physician

SIGNATURE (CHIEF OF SERVICE) AND DATE

PRINT NAME

SIGNATURE AND DATE

SIGNATURE AND DATE

PRINT NAME

SIGNATURE AND DATE

PRINT NAME

SIGNATURE AND DATE

PRINT NAME

SIGNATURE AND DATE

PRINT NAME

**RETURN THIS AGREEMENT
 (WITH THE ORIGINAL
 SIGNATURES) TO:**

**MARYLAND BOARD OF NURSING
 4140 PATTERSON AVENUE
 BALTIMORE, MD 21215
 ATTN: ADVANCE PRACTICE**



[ADDENDUM]

(SAMPLE FORM)
 NEW PROCEDURE AND COMPETENCY CHECK LIST

NAME	
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TO OBTAIN APPROVAL FOR PROCEDURES NOT PREVIOUSLY APPROVED. YOU MAY USE THIS FORM TO DOCUMENT ANY NEW PROCEDURE(S), AND SUBMIT IT TO THE BOARD. DO NOT INCLUDE A PROCEDURE ON THE WRITTEN AGREEMENT UNTIL COMPETENCY HAS BEEN OBTAINED. SUBMISSION OF THIS FORM (OR ONE OF YOUR CHOOSING) WILL INDICATE THAT THIS PROCEDURE IS TO BE ADDED TO THE CURRENT AGREEMENT.

TITLE OF PROCEDURE			
EDUCATION PROGRAM		DATES	
WORKSHOP		DATES	
OTHER		DATES	

DATE	OBSERVED	PERFORMED	EVALUATED BY	COMMENTS

I CERTIFY THAT _____ HAS PERFORMED THE ABOVE PROCEDURE AND IS COMPETENTLY AND INDEPENDENTLY.

SIGNATURE & DATE	TITLE
------------------	-------

PRINT NAME
