Midwifery
RECRUITMENT AND RETENTION

Application: For A LMC Midwifery Establishment Grant

DETAILS OF LMC MIDWIFE

Midwifery Council Registration Number: ☐☐☐☐☐☐☐

NZCOM Membership Number: ☐☐☐☐☐☐☐

Or

Name of Organisation Providing Indemnity: _____

Midwife Contact Details:

Surname or Family Name:

Christian (Given) Names:

Preferred Name:

Street Address:

Suburb / RD #:

City / Town:

Phone: ☐☐ ☐☐☐ ☐☐☐☐ **Fax:** ☐☐ ☐☐☐ ☐☐☐☐

Mobile: ☐☐☐☐☐☐☐☐☐☐

E-mail:

Sex: Female ☐ Male ☐ **Date of Birth:** ☐☐ ☐☐ ☐☐☐☐

NZ/European/Pakeha	☐	New Zealand Maori	☐	European	☐
Other Pacific	☐	Indian	☐	Niuean	☐
Cook Island Maori	☐	Tokelauan	☐	South East Asian	☐
Other Asian	☐	Samoan	☐	Tongan	☐
Fijian	☐	Chinese	☐	Other	☐

Bank Account Number (of the Practice): ☐☐ - ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐☐☐

(For Direct Credit Purposes)

GST Registered: Yes ☐ No ☐

My GST Number is: ☐☐☐☐☐ ☐☐☐

PRACTITIONER QUALIFICATIONS AND EXPERIENCE

Year of New Zealand Midwifery Registration: ☐☐☐☐

Country of Initial Registration:

☐ New Zealand ☐ UK ☐ Australia ☐ USA ☐ Europe

☐ Asia ☐ South Africa ☐ Pacific ☐ Other (specify) _____

Year of Initial Midwifery registration if country NOT New Zealand: ☐☐☐☐

Please list all maternity related qualifications you hold and the year gained

Details:	Year	Details:	Year
	☐☐☐☐		☐☐☐☐
	Year		Year
	☐☐☐☐		☐☐☐☐

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Full Name:	
Area you plan to establish the service in & distance (mins) from nearest base Maternity Facility.	
Will you be self employed or employed by a Trust / PHO or NGO (please specify)	
How many years experience as an LMC midwife in NZ?	

Planned (full) caseload per year _____

Number of LMC midwives practicing currently in the locality _____

	YES/NO
Plan to use the local primary maternity facility	
Plan to offer home birth	
Plan to provide a LMC midwifery service in the locality for more than 3 years	

Name & contact details of **local midwife** to verify establishment plans	
Name & contact details of **local maternity manager** to verify establishment plans	

Rationale for establishing a practice in this locality.

PLEASE SUPPLY YOUR BUSINESS PLAN AS SUPPORTING DOCUMENTATION
and any other material you believe may support your application.

Practice Partners **in new practice (please name)**

HPAC Agreement Number ☐☐☐☐☐☐-☐☐ **HPAC Payee Number:** ☐☐☐☐☐☐

CERTIFICATION

1. I certify the above information is true and correct. I am aware the information will be used in a matter consistent with the Health Information Privacy Code 1994.
2. I confirm that I am not currently under Midwifery Council processes such as competency review or competence programme, there are no complaints or cases against me before the Health and Disability Commissioner the Midwifery Council, the Professional Conduct Committee, ACC or the Health Practitioners Disciplinary Tribunal

Signature of PRACTITIONER _____ Date: