

Application: **For Rural LMC Midwifery Placement Support**
**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

## Application: **For Rural LMC Midwifery Placement Support**

<b>Full Name:</b>			
Area you would like a placement in.			
Where are you current working and in what role?			
How many years experience as an LMC midwife in NZ?			
Planned caseload per year in the placement _____			
			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 at least 3 years			

Name & contact details of a midwife colleague/employer to verify you current role.	
Why would you like to provide rural LMC services in this locality for the next 3 years.	

Describe the previous experience you have that would enhance your placement in this locality and work as an LMC midwife.

HPAC Agreement Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	HPAC Payee Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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### 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:** \_\_\_\_\_