

**PLEASE RETURN THIS FORM WITHIN 10 DAYS OF RECEIPT**

**The North Carolina Student Loan Program for Health, Science and Mathematics (HSM)  
N.C. STATE EDUCATION ASSISTANCE AUTHORITY  
10 Alexander Drive  
P.O. Box 14223  
Research Triangle Park, N.C. 27709-4223  
(919) 549-8614 or (800) 700-1775**

**APPLICATION FOR PROPOSED PRACTICE LOCATION  
FOR NURSE MIDWIFERY**

I. GENERAL

A. Name	Social Security No.	B. Current Home Phone (    )
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C. Current home address:

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D. Board certification

Date of License \_\_\_\_/\_\_\_\_/\_\_\_\_                      Licensure # \_\_\_\_\_

E. Do you have sub-specialty training?    No \_\_\_\_\_                      Yes \_\_\_\_\_

Specify: \_\_\_\_\_

II. PROPOSED PRACTICE

A. Geographic Location & Other Specific Data

1. County:	2. County Population:	3. Census Tract:	4. City:	5. City Population:
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6. Practice Address:	7. Practice Phone: (    )
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B. 'X' Type Practice:

\_\_\_\_\_ Institution (Name) \_\_\_\_\_

\_\_\_\_\_ Private (Obstetrician or other Physician) \_\_\_\_\_

\_\_\_\_\_ Partnership (Name Corporation or Partner) \_\_\_\_\_

\_\_\_\_\_ Other, specify \_\_\_\_\_

C. Are there any obstacles to health care accessibility in either of the following categories?

1. Economic (low income or lacking Medicare/Medicaid)
2. Non-Economic (minority status or language difference)
3. Physical Barriers (limited or bad roads, other)

\_\_\_\_\_ No      \_\_\_\_\_ Yes      Specify \_\_\_\_\_

D. Specify number of practitioners, in your field, who currently practice in the area, under each of the headings below:

Number of Practitioners

	Total	Working Part Time or Near Retirement Age	Accepting Medicare/Medicaid
OB-GYN			
Nurse Midwives			

III. PRACTICE PROPOSAL

A. Attach a statement of how you propose to serve the following groups: low income, Medicare/Medicaid recipients, migrants, prisoners, blind, minorities, disabled, etc.

B. Name of consulting obstetrician or physician actively practicing obstetrics:

Provider Number: \_\_\_\_\_

C. Office hours (40 hrs. per week considered full time)

Day Hours:	Evening Hours:	Saturday Hours:
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D. Days per week: \_\_\_\_\_

IV. DOCUMENTATION

Written evidence of need for Nurse Midwives in your proposed area must be submitted to this office in support of your application. Submit letters from the hospital administrator and the consulting physician.

Name	Title	Address
1.		
2.		
3.		
4.		

We must have written verification, within 30 days of your official beginning date, of your full time practice from an employer in which you practice.

Anticipated Practice Beginning Date: \_\_\_\_\_

Your Signature:

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_