



ANNUAL CERTIFIED DIRECT ENTRY MIDWIFE REPORT

State Form 56575 (9-18)

Pursuant to IC 25-23.4-4-4

**MIDWIFERY COMMITTEE
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
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INSTRUCTIONS:

1. Complete the certified direct entry midwife information.
(Note: The first annual report may be less than a twelve (12) month period. The second and subsequent years will be twelve (12) month periods.
Example: Initial license was effective June 1, 20x1. The first report will be for the period beginning June 1, 20x1 and ending December 31, 20x1. The second report will be for the period beginning January 1, 20x2 and ending December 31, 20x2. All subsequent reports will be for the period January 1 through December 31. All reports are due by March 31 of each year.)
2. Using the definitions and guidance given, complete items A through O below.

Certified Direct Entry Midwife Information

Name		License number
Address (number and street or PO Box, city, state, and ZIP code)		
Telephone number ()	Reporting period (month/day/year) Beginning: ____ / ____ / ____ Ending: ____ / ____ / ____	
Name of person completing this form		E-mail address of person completing this form

Definitions:
Referral: Referrals made pursuant to 844 IAC 17-1-9
Transfer: Any change in primary provider
Transport: Any emergency transfer to a hospital or similar emergency facility

Item	Number
A. Total Live Births	
B. Total Still Births	
C. Total Maternal Deaths	
D. Average Number of Weeks of Prenatal Care Provided	
E. Average Number of Weeks of Postpartum Care Provided	
F. Prenatal Referrals	
G. Intrapartum Referrals	
H. Emergency Intrapartum Transports	
I. Postpartum Referrals (non-urgent, non-emergency referral to another care system)	
J. Emergency Postpartum Transports	
K. Newborn Referrals (non-urgent, non-emergency referral to another care system)	
L. Emergency Newborn Transports	
M. Number of Mothers Breastfeeding at Six (6) Weeks Postpartum	
N. Intrapartum Transfers	
O. Prenatal Transfers	

Indicate reason(s) for all referrals pursuant to 844 IAC 17-1-9. Use additional sheets, if necessary.