Health and Human Services Licensure Unit
PO Box 94986
Lincoln NE 68509
402/471-4376 or fax 402/742-2360

NURSE MIDWIFE PRACTICE AGREEMENT

Between:

Name		Phone (H)	
Address		Phone (B)	
		APRN-CNM Lic No.	

Hereinafter referred to as a Nurse Midwife and legally defined as a Certified Nurse Midwife (APRN-CNM) who meets the requirements as defined in *Neb Rev Stat* §38-606 and who holds a current license as a APRN-CNM issued by the Department

and the collaborating physician(s) named below:

Physician Name		Physician Name	
Address		Address	
License #		License #	
Specialty		Specialty	
Physician Name		Physician Name	
Address		Address	
License #		License #	
Specialty		Specialty	

Hereinafter referred to as physician(s) and legally defined as a Nebraska licensed physician whose practice includes obstetrics.

at the practice sites identified below:

Office		Office	
Address		Address	
Hospital		Hospital	
Address		Address	
Public Health Agency		Public Health Agency	
Address		Address	

Whereas, the parties have developed this practice agreement provided for under Neb Rev Stat § 38-609 and 38-613; and

Now therefore, it is agreed by and between the physician(s) and the nurse midwife hereto:

This agreement shall not take effect until it has been completely executed and a copy has been filed in the office of the Department of Health & Human Services, Division of Public Health, Licensure Unit.

1. This agreement shall be continuous so long as conditions remain as agreed between parties on date of execution. Any change in terms of this agreement renders this practice agreement void. Any change in terms of practice agreement requires that an amendment to the agreement be filed with the Department of Health & Human Services, Division of Public Health, Licensure Unit and approval granted by the APRN Board. The APRN-CNM and collaborating physician have a duty to notify the Department of the termination of this agreement.
2. The collaborating physician(s) shall be responsible for supervision through ready availability for consultation and direction to the APRN-CNM when any delegated medical functions are provided by the APRN-CNM; and
3. The APRN-CNM and collaborating physician shall have jointly approved protocols for all delegated medical functions which shall guide the APRN-CNM's practice. The protocols shall be reviewed, updated, and reaffirmed by both parties on a regular basis and no less frequently than every two (2) years. Protocols must be available at all work sites; and
4. The specific medical functions delegated to the nurse midwife shall be based upon the educational preparation and continued experience of the nurse midwife. Validation, including documentation, of education/training and assessment of competency shall be the responsibility of the nurse midwife and the physician. Specific medical functions may include:
   a) attending cases of normal childbirth;
   b) providing prenatal, intra-partum, and postpartum care;
   c) providing normal obstetrical and gynecological services for women;
   d) providing care for the newborn immediately following birth; and
   e) prescribing legend drugs, Schedule II controlled substances for up to 72 hours and for pain control, and Schedule III, IV, and V controlled substances.
   f) An APRN-CNM may assist with cesarean sections

STATE OF_____ COUNTY OF_____

I, _____ confirm that I am the person referred to in this Practice Agreement as a nurse practitioner in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Legal Signature of Applicant _____

Date _____

STATE OF_____________________________ COUNTY OF_________________________________

I, ____ confirm that I am the person referred to in this Practice Agreement as a physician in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Legal Signature of Applicant ____

Date ___________________________

STATE OF_____________________________ COUNTY OF_________________________________

I, ____ confirm that I am the person referred to in this Practice Agreement as a physician in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Legal Signature of Applicant ____

Date ___________________________

STATE OF_____________________________ COUNTY OF_________________________________

I, ____ confirm that I am the person referred to in this Practice Agreement as a physician in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Legal Signature of Applicant ____

Date ___________________________

STATE OF_____________________________ COUNTY OF_________________________________

I, ____ confirm that I am the person referred to in this Practice Agreement as a physician in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Legal Signature of Applicant ____

Date ___________________________