MONTANA BOARD OF ALTERNATIVE HEALTH CARE
301 SOUTH PARK, 4th FLOOR
PO BOX 200513
HELENA MONTANA 59620-0513
(406) 841-2203 FAX (406) 841-2305
EMAIL: dlibsdahc@mt.gov WEBSITE: www.althealth.mt.gov

DIRECT-ENTRY MIDWIFE LICENSURE IN MONTANA

THIS IS AN INFORMATION SUMMARY SHEET ONLY. THE APPLICANT IS RESPONSIBLE FOR READING THE COMPLETE STATUTES AND RULES PRIOR TO MAKING APPLICATION. APPLICATIONS MUST BE APPROVED BY THE BOARD MEMBERS. AVERAGE APPROVAL TIME, AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION, IS 90 DAYS. A COMPLETED APPLICATION MUST BE RECEIVED BY THE BOARD 15 BUSINESS DAYS PRIOR TO A SCHEDULED BOARD MEETING. PLEASE REFER TO OUR WEBSITE FOR BOARD MEETING DATES.

DIRECT-ENTRY MIDWIVES ARE NOT PERMITTED TO PRACTICE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA LICENSE

LICENSURE REQUIREMENTS

DIRECT-ENTRY MIDWIFE LICENSURE BY EXAMINATION: Applicant is not licensed in any other state as a direct-entry midwife. Applicant must:

1) be of good moral character;
2) possess a high school diploma or its equivalent;
3) be at least 21 years of age;
4) pass the North American Registry of Midwives licensing exam (NARM) with a score of 75 or better or an exam endorsed by the Board;
5) have filed documentation that the applicant has been certified to perform adult and infant cardiopulmonary resuscitation. Certification must be current at the time of application and remain valid throughout the license period.
6) have filed documentation that the applicant has been certified to perform neonatal resuscitation. Certification must be current at the time of application and remain valid throughout the license period.
7) have demonstrated to the Board that the educational and supervised, practical experience requirements in 37-27-201(3) and (4) have been met; and
8) have submitted a complete application accompanied by the appropriate fee and all supporting documents.

DIRECT-ENTRY MIDWIFE LICENSEES FROM OTHER STATES: Applicant must:

1) have a current license in good standing from a state or jurisdiction whose license was issued under standards equivalent to or greater than current standards in this state (i.e., meet standards 1-7 above) and;
2) provide verification from the state or states in which the applicant is licensed that the applicant is not subject to pending charges or final disciplinary action for unprofessional conduct or impairment.

DIRECT-ENTRY APPRENTICES: Applicant must:

1) work only under direct supervision (within the physical presence) of an approved supervisor who has completed the Board's supervision form;
2) have filed documentation that the applicant has been certified to perform adult and infant cardiopulmonary resuscitation. Certification must be current at the time of applicant and remain valid through the license period.
3) have submitted a curriculum outline or method of academic learning that meets the Board's education requirements for licensure (MW Form 1 completed);
4) have submitted a complete application accompanied by the appropriate fee and all supporting documents.

FEES: $300 Midwife App Fee Midwife Apprentice App fee $200

$200.00 Midwife Original Licensee Fee to be paid Upon Board Approval of Application

DOCUMENTS: The following documents must be submitted to the Board office in order to complete your license application. **The completed application and all supporting documents submitted by you** must be received 15 business days prior to a Board meeting.

FOR DIRECT-ENTRY MIDWIFE EXAMINATION CANDIDATES:

1) Application fee of $300 (non-refundable) made payable to the Board of Alternative Health Care.
2) Certified copy of transcript verifying graduation sent directly to the Board office from the high school or GED verifying agency.
3) Documentation of good moral character consisting of three letters of reference, at least one of which must be from a licensed direct-entry midwife.
4) A copy of a current CPR card indicating that the applicant is certified by the American Heart Association or the American Red Cross to perform adult and infant cardiopulmonary resuscitation.
5) A copy of a current neonatal card indicating that the applicant is certified by the American Heart Association or the American Academy of Pediatrics to perform neonatal resuscitation.
6) Completed "Direct-entry Midwife Education Standards Form" (Form #1).
7) Completed "40 Birth Observations Form" (Form #4) with identifying information redacted.
8) Completed forms documenting provision of 100 prenatal examinations (Form #5) with identifying information redacted.
9) Completed "Documentation of Birth Experience Form" which certifies that the applicant has served as the primary birth attendant at 25 births, 15 of which include continuous care - 10 of the continuous care births must have been under personal supervision (Form #2). All identifying information must be removed.

FOR DIRECT-ENTRY MIDWIFE CANDIDATES FROM OTHER STATES:

1) Documents described in 1-9 above on Board forms. All identifying information must be removed from records submitted to the Board.
2) Applicants with licenses from other states must contact other states of licensure (past & current) and request letters of verification of license status to be sent directly to the Board office from the licensing jurisdiction. **The candidate will be responsible for contacting these jurisdictions and paying any fees that are required.**
3) Candidate will have the exam agency supply directly to the Montana Board documentation of successful completion of the North American Registry of Midwives (NARM) exam with a score of 75 or higher or document passage of an exam endorsed by the Board.
4) Candidate shall supply a copy of the laws and rules which were in effect at the time the license was granted in the other jurisdiction.

FOR DIRECT-ENTRY MIDWIFE APPRENTICES

1) A copy of a current CPR card indicating that the applicant is certified by the American Heart Association or the American Red Cross to perform adult and infant cardiopulmonary resuscitation.
2) Application fee of $200 (non-refundable) made payable to the Board of Alternative Health Care.
3) Completed supervision agreement (Form #3).
4) Curriculum outline or plan for method of academic learning that meets the Board's educational requirements for licensure (MW Form 1 must be completed).

When the apprentice license is issued, you will receive the Level 1 Forms Packet.

APPLICATION PROCEDURES

- When the application file is complete, it will be processed and considered by the Board at a meeting. The applicant may be notified if additional information is required.
- If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board Meeting.
- All verifications of licensure must be sent directly from each state board in which the applicant is currently or has ever been licensed. Some states may charge a fee for verifications. Contact each state board prior to sending the request.
- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

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Application for Licensure as:

☑ Direct-Entry Midwife
☐ Direct-Entry Apprentice

Application by:

☐ Examination
☐ License from Another State

1. FULL NAME _____ (Last) _____ (First) _____ (Middle)
2. OTHER NAMES KNOWN BY _____
3. BUSINESS NAME _____
4. BUSINESS ADDRESS _____ (Street or PO Box #) _____ (City and State) _____ (Zip) _____ (Country)
5. HOME ADDRESS _____ (Street or PO Box #) _____ (City and State) _____ (Zip) _____ (Country)

PREFERRED MAILING ADDRESS ☐ Business ☐ Home EMAIL ADDRESS _____

6. TELEPHONE _____ (Business) HOME _____ FAX _____
7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____
8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ◯ MALE ◯ FEMALE
9. LICENSE NAME _____
(State your name as it should appear on the license if granted.)

10. List all professional licenses you hold or ever have held. Verification must be sent directly to Montana from each state, province, or territory.

State	License#	Issue Date	Exp.Date	License Method	Requested Verification?
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO

Please answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a Supplement Sheet.

11. If taking an examination, do you have any physical or mental impairment(s) requiring special accommodation(s)? ◯ Yes ◯ No

12. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

13. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

14. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

15. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

16. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

17. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. ◯ Yes ◯ No

18. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupation license in anticipation of or during an investigation or disciplinary proceeding or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

19. Has a complaint ever been made against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

20. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/ Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. ◯ Yes ◯ No

21. Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. ◯ Yes ◯ No

22. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. ◯ Yes ◯ No

23. Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source. ◯ Yes ◯ No

24. Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. ◯ Yes ◯ No

25. Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years ago and that resulted in fines of less than $200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. ◯ Yes ◯ No

26. Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. ◯ Yes ◯ No

27. Have you ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation. ◯ Yes ◯ No

28. Have you ever been court-martialled or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation for the source. ◯ Yes ◯ No

29. **PROFESSIONAL EDUCATION:**

Name of University or College	City and State/Province/Territory	Dates Attended	Degree Earned

Name of School	City and State/Province/Territory	Dates Attended	Degree Earned

30. **PROFESSIONAL EXPERIENCE AS A MIDWIFE:** Midwife - List all experience, unpaid as well as paid, concurrent as well as consecutive, starting at the date of application and working back to graduation from your high school. Use additional sheet if necessary.

Name & Location of Practice	Activity/Position	Inclusive Dates	Reason for Leaving

MAINTAINING CONFIDENTIALITY OF APPLICATION DOCUMENTS

When submitting application documents, I understand that I am responsible for ensuring client confidentiality in records submitted to the Board. Application records are scanned and stored electronically. All identifying information must be removed from records submitted to the Board.

DECLARATION

I authorize the release of information concerning my competence to practice, by anyone who might possess such information, to the Montana Board of Alternative Health Care.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and am familiar with the applicable licensure laws of the State of Montana and instruction to applicants for licensing. I accept the rules and procedures for licensing. I accept the rules and procedures outlined in these documents as the basis for my application.

Signature of Applicant

Dated

VERIFICATION OF MORAL/PROFESSIONAL CHARACTER

APPLICANT: Complete the upper portion of this form and mail to each of the character references you have listed in your application.

_____ _____

Legal Signature of Applicant Date

(Please Type or Print)
Name of Applicant: _____

Address: _____

This verification sent to: _____

CHARACTER REFERENCE: Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to the Montana Board of Alternative Health Care. Your response will be kept confidential.

Name of reference: _____ Daytime phone: _____

Address: _____

Title/profession/position: _____

How long have you known the applicant? _____ In what capacity? _____

To your knowledge, does the applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes", please explain:

Do you consider this applicant worthy of approval to practice as a _____ in Montana?

Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed):

_____ _____

Signature of Reference Date

The Applicant and the Board thank you for your assistance.

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DIRECT-ENTRY MIDWIFE EDUCATION STANDARDS

Please indicate the direct-entry midwife program or course of study which demonstrates competence in each of the substantive content areas listed below. Submit course and program descriptions, from the time of applicant's graduation or completion, and certificates of completion or certified transcripts sent directly from the institution to verify that the training received fulfills minimum educational standards.

Antepartum Care

(1) Preconceptional factors likely to influence pregnancy outcome:

(2) Basic genetics, embryology and fetal development:

(3) Anatomy and assessment of the soft and bony structure of the pelvis:

(4) Identification and assessment of the normal changes of pregnancy, fetal growth, and position:

(5) Nutritional requirements for pregnant women and methods of nutritional assessment and counseling:

(6) Environmental and occupational hazards for pregnant women:

(7) Education and counseling to promote health throughout the child bearing cycle:

(8) Methods of diagnosing pregnancy:

(9) The etiology, treatment and referral, when indicated, of the common discomforts of pregnancy:

(10) Assessment of physical and emotional status, including relevant historical and psycho-social data:

(11) Counseling for individual birth experiences, parenthood, and changes in the family:

(12) Indications for, risks and benefits of screening/diagnostic tests used during pregnancy:

(13) Etiology, assessment of, treatment for, and appropriate referral for abnormalities of pregnancy:

(14) Identification of, implications of and appropriate treatment for various STD/vaginal infections during pregnancy:

(15) Special needs of the Rh negative woman:

(16) Identification and care of women who are HIV positive, have hepatitis or other communicable and non-communicable diseases:

Intrapartum Care

(1) Normal labor and birth processes:

(2) Anatomy of the fetal skull and its critical landmarks:

(3) Parameters and methods for assessing maternal and fetal status, including relevant historical data:

(4) Emotional changes and support during labor and delivery:

(5) Comfort and support measures during labor, birth, and immediately postpartum:

(6) Techniques to facilitate the spontaneous vaginal delivery of the baby and placenta:

(7) Etiology, assessment of, appropriate referral or transport of and/or emergency measures (when indicated) for the mother or newborn for abnormalities of the four stages of labor:

(8) Anatomy, physiology, and supporting normal adaptation of the newborn to extrauterine life:

(9) Familiarity with medical interventions and technologies used during labor and birth:

(10) Assessment and care of the perineum and surrounding tissues, including suturing necessary for perineal repair:

Postpartum Care

(1) Anatomy and physiology of the postpartum period:

(2) Anatomy and physiology and support of lactation, and appropriate breast care and assessment:

(3) Parameters and methods for assessing and promoting postpartum recovery:

(4) Etiology and methods for managing the discomforts of the postpartum period:

(5) Emotional, psycho-social and sexual changes which may occur postpartum:

(6) Nutritional requirement for women during the postpartum period:

(7) Etiology, assessment of, treatment for and appropriate referral for abnormalities of the postpartum period:

(8) Methods to assess the success of the breast feeding relationship and identify lactation problems, and mechanisms for making appropriate referrals:

(9) Suturing necessary for episiotomy repair:

(10) Dispensing and administering pitocin (intramuscular) postpartum:

(11) Dispensing and administering xylocaine (subcutaneous)

Neonatal Care

(1) Anatomy and physiology of the newborn's adaptation and stabilization in the first hours and days of life:

(2) Parameters and methods for assessing newborn status, including relevant historical data at gestational age:

(3) Nutritional needs of the newborn:

(4) ARM and MCA standards for an administration of prophylactic treatments commonly used during the neonatal period:

(5) ARM and MCA standards for, indications, risks, and benefits of, and method of performing common screening tests for the newborn:

(6) Etiology, assessment of (including screening and diagnostic tests), emergency measures and appropriate transport/referral or treatments for neonatal abnormalities:

Health and Social Sciences

(1) Communication, counseling and teaching techniques, including the areas of client education and inter-professional collaboration:

(2) Human anatomy and physiology relevant to human reproduction:

(3) ARM and MCA standards of care, including midwifery and medical standards for women during the childbearing cycle:

(4) Inter-professional communication and collaboration with community health and social resources for women and children:

(5) Significance of and methods for thorough documentation of client care through the childbearing cycle:

(6) Informed decision making:

(7) Health education, health promotion, and self care:

(8) The principles of clean and aseptic techniques, and universal precautions:

(9) Psychosocial, emotional and physical components of human sexuality, including indications of common problems and method of counseling:

(10) Ethical considerations relevant to reproductive health:

(11) Epidemiologic concepts and terms relevant to perinatal and women's health:

(12) The principles of how to access and evaluate current research relevant to midwifery practice:

(13) Family centered care, including maternal, infant and family bonding:

(14) Identification of an appropriate referral of disease in women and their families:

(15) The importance of accessibility, quality health care for all women that includes continuity of care, and special requirements for home births:

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DOCUMENTATION OF BIRTH EXPERIENCE

Name _____

Address _____

City _____ State _____ Zip Code _____

Country _____

BIRTH EXPERIENCE REQUIREMENTS: Applicant must document participation as the **primary birth attendant at 25 births**, 15 of which must have included continuous care.

Continuous care is defined as a birth which has at least five prenatal visits, one of which must have been performed before the beginning of the 28th week of gestation, as determined by the last menstrual period or sonogram, and includes one postnatal visit. The Board of Alternative health Care will accept a birth that has been transported to the hospital as long as the other continuous care requirements have been met.

Ten of the 15 continuous care births must have occurred under the direct supervision of a qualified supervisor.

Submit a copy of your records that show the continuous prenatal care (where needed), birth, and postnatal records. Staple the pages together for each birth submitted, approximately 3 pages per birth. Number your records in date-of-birth order (oldest birth first) and record the date-of-birth #1 on line #1 and indicate whether it is a continuous care birth and whether it was done under direct supervision. Have your supervisor sign off for approval where indicated. ALL IDENTIFYING INFORMATION MUST BE REMOVED FROM RECORDS SUBMITTED TO THE BOARD.

Oldest Birth First	Date of Birth	Continuous Care? (15)	Direct Supervision? (10)	Supervisor's Approval
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Oldest Birth First	Date of Birth	Continuous Care? (15)	Personal Supervision? (10)	Supervisor's Approval
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
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19.				
20.				
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23.				
24.				
25.				

I have fully read and understand this experience form and the information given herein is true, correct, and complete, including all documentation submitted with this form. If so requested by the Montana Board of Alternative health Care, I will furnish all additional information or documentation as may be deemed necessary for the verification of the information given here. I acknowledge that this form may be disapproved for cause and than any license/certification that I may obtain may be revoked for supplying false or misleading information to the Montana Board of Alternative Health Care.

Legal Signature of Applicant

Date

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DOCUMENTATION OF 40 BIRTH OBSERVATIONS

Name _____ Apprentice License # _____

Address _____

City _____ State _____ Zip Code _____

INSTRUCTIONS: List in chronological order - oldest birth observation date first. All identifying information must be removed from records submitted to the Board.

Oldest Birth First	Date of Birth	Parent's Initials or ID Number	Baby's First Name	Supervisor's Initials
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Date of Birth (oldest first)	Date of Birth	Parent's Initials or ID Number	Baby's First Name	Supervisor's Initials
21.				
22.				
23.				
24.				
25.				
26.				
27.				
28.				
29.				
30.				
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EVALUATION OF PRENATAL EXAMS - LEVEL _____

Name _____ License # _____

Supervisor _____ License # _____

INSTRUCTIONS: List in chronological order - oldest exam date first. Indicate at the top which level the form is being used for and fill in the appropriate number of prenatal exams. Level I requires 20 exams. Level II and Level III require 40 exams. All identifying information must be removed from records submitted to the Board.

Oldest Exam Date First	Date of Prenatal Exam	Parent's Initials or ID Number	Supervisor's Initials
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

MW - Form 5
Revised 02/07, 3/08, 11/10

Oldest Exam Date First	Date of Birth	Parent's Initials or ID Number	Supervisor's Initials
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
30.			
31.			
32.			
33.			
34.			
35.			
36.			
37.			
38.			
39.			
40.			

Instructions: To be initialled by your supervisor if successfully completed.

Performs all components of routine prenatal exam:

	Assess fundal height/fetal growth/fetal weight
	Locate and count fetal heart tones
	Assess intrauterine fetal presentation and position
	Assess engagement and flexion (if appropriate)
	Cervical ripeness (if appropriate)
	Assess weight gain
	Assess blood pressure
	Assess urinalysis an dip stick
	Assess/do appropriate lab work
	Conduct appropriate client education

Supervisor's Comments:
(Please attach additional sheet if necessary.)

Supervisor's Signature

Date

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REQUEST FOR OFFICIAL VERIFICATION OF LICENSURE

(THIS IS NOT AN ENDORSEMENT CERTIFICATION)

APPLICANT: Do **NOT** send this form in with your application. This is to be used as necessary to request official license verification from states or licensing entities in which you currently hold, or ever have held a license.

COMPLETE THE FORM AND MAIL IT TO ANY STATE BOARD IN WHICH YOU ARE REQUESTING OFFICIAL LICENSE VERFICATION BE SENT TO THE MONTANA ALTERNATIVE HEALTHCARE BOARD. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. BE ADVISED THAT SOME BOARDS REQUIRE A FEE FOR THIS SERVICE. IT IS RECOMMENDED YOU CONTACT THE BOARDS BY PHONE PRIOR TO MAILING IN THIS FORM TO SEE IF YOU NEED TO INCLUDE PAYMENT.

LICENSEE INFORMATION

To Whom It May Concern:
I am applying for a license to practice _____ in the State of Montana and the Alternative Healthcare Board requires official license verification.This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to:

Montana Alternative Healthcare Board
PO Box 200513
Helena, MT 59620-0513.

Your prompt response is appreciated.

Name (Please Print) _____ Signature _____

Address: _____

_____
Street or PO Box # City State Zip

My License Number from your State is: _____ License Type: _____

This form is to be used to request official verification from states where you hold or have ever held a license. Please **DO NOT** return this form to our office.