Licensed Midwife Attestation:
Plan for Consultation, Emergency Transfer, & Transport

Midwife Name *(as listed on license)*	License#	Date

Please describe your plan of care, for the following:

1. In the event of an emergency:

2. In an emergency transport to the hospital, the following are available:

☐ **Private Ambulance Name** | **Phone** | **Fax**

Address | **City** | **ZIP**

☐ **Municipal Aid Care Name** | **Phone** | **Fax**

Address | **City** | **ZIP**

3. In the event of a maternal emergency in an out-of-hospital setting, I will transport to the following:

Hospital Name | **Phone** | **Fax**

Address | **City** | **ZIP**

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4. In the event of a neonatal emergency in an out-of-hospital setting, I will transport to the following:

Hospital Name	Phone	Fax

Address	City	ZIP

5. Licensed physician(s) engaged in active clinical obstetrical practice and with whom I consult when there are significate deviations from the normal, in either mother or the infant is:

PRIMARY (required)
(Please note: the covering physician must be participating in the IEHP Network:

Physician's Name *(as listed on license)*	License#	Individual NPI

Group Name	Phone	Fax

Address	City	ZIP

SECONDARY (optional)
(Please note: the covering physician must be participating in the IEHP Network:

Physician's Name *(as listed on license)*	License#	Individual NPI

Group Name	Phone	Fax

Address	City	ZIP

By signing below, I ________________________________, LM hereby attest to the written plan of care provided above.

Licensed Midwife (LM) signature	Date