

## Application to Join an Existing Alternate Practice Arrangement

This form is to be completed by midwives who wish to join an existing Alternate Practice Arrangement (APA). For more information, please refer to the *Policy on Alternate Practice Arrangements*.

### A. Midwife Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Middle name: \_\_\_\_\_ Former name(s) if applicable: \_\_\_\_\_

Date (mm/dd/yy): \_\_\_\_\_ BCCNM ID: \_\_\_\_\_

APA practice name: \_\_\_\_\_

APA practice address (Apt/Box/#/Street): \_\_\_\_\_ City/town: \_\_\_\_\_

Province/State: \_\_\_\_\_ Country: \_\_\_\_\_ Postal code/zip code: \_\_\_\_\_

APA practice partners: \_\_\_\_\_

### B. Standards of Practice Deviations

1. Please list any new competencies, skills and/or knowledge that you will gain while working in an APA that may be useful to midwifery practice if and when you return to the Standard Model?

2. Please list any competencies, skills and/or knowledge that may require support to regain if and when you return to the Standard Model? (e.g., home birth services, postpartum care, etc.)

### C. Declaration

- I agree to inform my clients that the midwifery care they are receiving is within the context of an Alternate Practice Arrangement.
- I have reviewed BCCNM's *Policy on Alternate Practice Arrangements*, Midwives Regulations, and BCCNM Bylaws, and agree to provide care consistent with the standards outlined in these documents.

Signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_