



Washington State Department of  
**HEALTH**  
 Midwifery Credentialing  
 P.O. Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Midwife Medical Devices Extension Clinical Experience

**Applicant Name:** \_\_\_\_\_

If using multiple licensed healthcare professionals, use a separate form for each provider.

Medical Device Removal	Date	Client ID	Licensed Healthcare Professional Initials
1.			
Medical Device Insertion	Date	Client ID	Licensed Healthcare Professional Initials
1.			
2.			
3.			

The clinical experience must be directly supervised by a licensed health care professional who, within their scope of practice, is qualified and has at least two years of experience administering medical device insertions and removals.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I attest that the applicant has shown the proper knowledge and skills to insert and remove medical devices and I have at least two years of experience in administering medical devices.

Licensed Health Care Professional Name (please print): \_\_\_\_\_

License Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [doh.information@doh.wa.gov](mailto:doh.information@doh.wa.gov).