National Midwifery Institute
INCORPORATED

PRECEPTOR HANDBOOK

UPDATED 2020

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INTRODUCTION

Dear Midwives,

Welcome! Thank you in advance for your dedication not only to your practice and serving your community, but also to the prospect of training more midwives. We all want to see midwifery models of care can expand, deepen, and become more common in all communities, most especially in marginalized and under-resourced communities. Thank you for doing your part!

This handbook is meant to orient you to the National Midwifery Institute Education Program, and help you understand the responsibility of precasting one of our students, as well as the benefits to you for doing so. We hope this proves a fruitful relationship for both the student midwife, and for you, your practice, your clients, and your community.

Should you have any questions or concerns throughout your time as a preceptor, whether with your student's progress, required paperwork, understanding clinical experience requirements, or more, please feel free to reach out to me at anytime.

Thanks for all you do!

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STRUCTURE OF NMI

National Midwifery Institute, Inc. is a *correspondence midwifery program,* meaning students complete their education online. Our students study in their home communities through online communication with coursework instructors and study groups, and complete direct midwifery apprenticeships to gain clinical skills. Our program consists of a three-part formula incorporating antepartum, intrapartum, postpartum, newborn, and lifelong reproductive health care, plus beginning, intermediate, and advanced practica. All NMI Students complete:

1) **Heart & Hands Course Work:** completion of thirteen modules (beginning and advanced levels) as an introduction to the art and practice of midwifery.
   Some students complete Heart and Hands as an in-person series of workshops, others complete it at-a-distance.

2) **Study Group Course Work:** completion of fifty-four modules diving deep into individual clinical, practical, and social aspects of midwifery

3) **Supervised Apprenticeship:** completion of clinical experience meeting the requirements of NARM CPM certification and California Midwifery Practice Act.

Meeting NMI curricular requirements requires a high degree of self-motivation. Correspondence education means that there is no classroom, thus students must be well organized and prepared to maintain their commitment to studying and completing assignments. Course work is submitted to instructors through email. Students work at their own pace within the framework of NMI's minimum clinical and academic progress policies. A student may use the flexibility of these policies to better maintain their other adult responsibilities.

Students are responsible for securing an apprenticeship. While apprenticing, students should expect to make a full time commitment, as most situations require 24/7, on-call availability. If a student is studying full time (25 hours per week or more spent on course work and clinical training), program requirements can be completed in approximately three years. On the other hand, a student who chooses a preceptor with a relatively low client volume may need more time to complete the program whereas a student in a high-volume apprenticeship might finish in less than three years. NMI designates a maximum time frame for program completion; our students are guided by NMI Student Academic Progress and Student Clinical Progress policies to complete the program **within seven years**. NMI acknowledges its students as adult learners, and values the dynamic potential they bring to their education based on cumulative life experience, philosophy, and belief system. Faculty and administration are committed to helping students integrate their personal, didactic, clinical, and professional experiences.

NMI Philosophy & Purpose

We believe that the study of midwifery is a self-motivated and organic process, springing forth from the fertile ground of community and family. Just as there have always been and will always be birthing women and birthing people, so the midwife is called into practice. It is our experience that the midwifery model of care is best upheld by students who have trained in their own communities and have become an integral part of the local birth network by the time they are ready to work independently.

We further believe that birth is a transformational process for everyone involved, with its own intrinsic value for personal growth and development. We support woman-centered and pregnant person-centered birth and seek to uphold the rights of women and pregnant people to define their needs and identify their support systems. While midwives set parameters of safety, it is birthing women and birthing people who, through the process of informed consent, make decisions regarding their care and the care of their babies.

In the context of midwifery education, we hope to prepare students to practice skillfully, artfully, and sensitively. We are inspired by students' curiosity and love of learning. Motivated by the memory of our teachers, we support students in forming healthy, egalitarian relationships with instructors, preceptors, clients, fellow students, and other professional colleagues. We are driven to teach students to take responsibility for themselves both personally and professionally.

It is our purpose to prepare midwives for the scope of practice outlined by the Midwives Alliance of North America (MANA) core competencies, the North American Registry of Midwives (NARM) certification guidelines, the California Midwifery licensing requirements as well as many other state licensure requirements, and International Confederation of Midwives (ICM) International Definition of the Midwife.

NMI Mission

Our mission is to provide exceptional decentralized, apprenticeship-based direct-entry midwifery education. Our program prepares aspiring midwives to provide comprehensive midwifery care while studying in their own communities and fully in touch with the individuals and families they serve, to assure that the choice of sensitive, competent midwifery care may be more readily available to birthing people and their families everywhere.

PRECEPTING NMI STUDENTS

In order to become a preceptor for an NMI student, preceptors must meet the qualifications noted on the following pages *Qualifications for NMI Preceptors*. In addition, if a student plans to apply for licensure in a particular state, and to become a *Certified Professional Midwife (CPM),* NMI recommends all preceptors be registered with the *North American Registry of Midwives* and meet their Requirements for Preceptors noted on the following pages *Qualifications for NARM-Approved Preceptors.* Certain states, regions, or countries may require additional preceptor registration, paperwork, or qualifications. This is up to the individual Student and Preceptor to research and take accountability for.

New NMI Preceptors are required to complete paperwork including acknowledgement of NMI policies and requirements, Preceptor-Student Agreements, Compensation Documentation, and more. This paperwork packet will be sent to you electronically upon enrollment as a preceptor. This packet may be updated overtime, and current preceptors may be required to meet new requirements within a reasonable timeframe. Preceptors may be required to submit new/additional paperwork when registering with new NMI students, even if they have precepted for NMI before.

NMI Students are expected to begin apprenticeship within certain timeframes after enrolling with the program:

- **Within 36 months of initial enrollment**: student must secure an apprenticeship
- **Within 42 months of initial enrollment:** student must begin filing documentation of non-primary experience (observes, assists)
- **Within 60 months of initial enrollment:** student must begin filing documentation of Supervised Primary Care

NMI Students and their preceptors working together are expected to turn in clinical experience documentation on a rolling basis, ideally completed as soon after the experience as possible.

NMI is currently working with the NMIClinicalTracking App, where students and preceptors have the opportunity to complete clinical experience documentation electronically. You will be sent a separate handbook with instructions in how to use this App. If you do not want to use the App, you and your student(s) may use paper forms. Please note all forms were updated in June, 2020. All forms used should be the most current versions available.

QUALIFICATIONS FOR NMI PRECEPTORS

National Midwifery Institute is an equal opportunity employer and educational institution. There shall be no discrimination against any employee, applicant for employment, preceptor, or any student on any basis including actual or perceived sex, gender identity, race, color, marital status, ethnic origin, religion, age, sexual orientation, or disability. This non-discrimination policy applies to all educational policies and programs and to all terms and conditions of employment, which include (but are not limited to): recruitment, hiring, training, compensation, benefits, promotions, disciplinary actions and termination.

Precepting faculty for National Midwifery Institute must be health professionals providing primary care for pregnancy, birth, postpartum, and newborn care, and may also provide reproductive healthcare services for their communities and birth care in an out-of-hospital setting. This may include midwives (LMs, RMs, CPMs, CNMs, etc.), family practice physicians, and other care providers. As precepting midwives observe and document increasing skill in their apprentices, they are expected to respond by making additional responsibilities and practice opportunities available to students at an appropriate rate for their acquisition and in accordance with their practice policies.

All precepting faculty must:

- Agree to uphold NMI program goals, the Philosophy and Purpose Statement, and the Mission Statement;
- Demonstrate an effective teaching style, incorporating student input and feedback;
- Work cooperatively with other faculty;
- Complete cultural sensitivity/diversity training or course work;
- Evaluate student progress according to the required schedule;
- Complete and document 30 hours of continuing education every three years (consistent with NARM CEU policy);
- Maintain a professional ethic (as defined by the MANA Statement of Values and Ethics) upholding student confidentiality at all times;
- Agree to participate in conflict resolution, utilizing the program's Grievance Mechanism as necessary;
- Respond appropriately to the suggestions arising from the annual NMI program review.
- Be in active midwifery practice in an out-of-hospital setting;
- Be certified or licensed by a mechanism recognized in their jurisdiction, or maintain the CPM credential where midwifery is not regulated and not prohibited by enforcement of existing law;
- Periodically attend peer review. Preceptors are encouraged to include students in routine peer review, if acceptable within the local midwifery community.

If an NMI Student also plans to sit for the NARM exam to become a CPM, and/or be licensed in their own state/province/jurisdiction, there may be additional requirements.

Preceptor Rights and Responsibilities

Precepting faculty maintain or participate in primary midwifery practices, providing prenatal, intrapartum, postpartum, and reproductive health family planning care and upholding:

1) NMI program goals;
2) the Midwives Model of Care;
3) professional standards of practice; and
4) the MANA Statement of Values and Ethics.

Precepting midwives attend clients in the out-of-hospital setting of their choice. Students are introduced to their preceptor's clients as members of the care team, but clients must be fully informed of the student's status and must give consent for the student's participation in their care. The precepting midwife's first responsibility is to uphold parameters of safety while providing quality care and continuity to clients; within that context, the student shall be given every opportunity to acquire clinical experience and skill required for program completion.

Once a preceptor and student agree to work together, they complete and sign the **NMI Apprentice/Preceptor Work Agreement** and **Informed Consent Worksheet**. This document must include the following information regarding preceptor's practice:

- philosophy
- experience and training
- certification or licensure status
- malpractice insurance status
- numbers of clients both for the previous year and current year
- number of students the preceptor has trained
- number of students the preceptor takes into the practice at a time (with breakdown of learning opportunities for each student)

The **Informed Consent Worksheet** may also include a list of the apprentice's expectations of training; however, it is the precepting midwife's responsibility to formulate and file this document. The preceptor/student relationship is formalized when this document has been signed and a copy is filed with the NMI office. Precepting faculty are also responsible for updating their teaching methods and clinical practice in keeping with current standards of care. On the basis of student evaluation and NMI annual review, they are also expected to incorporate student input in their method and style of precepting.

All faculty are responsible for documenting continuing education consistent with current NARM requirements (as of 7/2018, 30 contact hours of continuing education every three years).

Faculty are also responsible for participation in **annual program review**, completing the online survey each year that is initiated by May 5th (International Midwives Day).

Preceptor Benefits and Honoraria

For students enrolled PRIOR to June 2019, approved NMI preceptors are entitled to invoice NMI for an honorarium, paid for by student tuition. Upon preceptor enrollment, preceptors will be asked if they want to invoice NMI for this honorarium throughout their time precepting for NMI, or waive this honorarium and make other arrangements with their apprentice directly. If a preceptor waives their honorarium, these funds will be returned to the student upon graduation.

An approved NMI preceptor may invoice the program for a total honorarium of $3400 per student (limited to the minimum requirements for each experience category):

- up to 10 observe births @ $10 each;
- up to 55 student-assist exams and 195 preceptor supervised student-primary care exams @ $10 each;
- up to 20 student-assist births @ $15 each;
- and up to 25 preceptor supervised student-primary care births @ $20 each.

Most preceptors realize adequate exchange with an apprentice via assistance with the practice and honorarium from NMI. However, it is possible that a preceptor will charge a student additional fees. Students are responsible for this as a separate agreement; NMI limits payment to preceptors as described above. If a preceptor requires additional fees, that independent agreement with the student *disqualifies the preceptor from also invoicing NMI for the preceptor honorarium amounts.*

For students enrolled AFTER June 2019, the preceptor honorarium is no longer an option. If preceptors require financial compensation for their efforts, this is to be arranged with the student directly. No fees will be returned to the student upon graduation.

All approved NMI preceptors may also take advantage of the following benefits:

- access to the **NMI Media Library** including books, DVDs, subscriptions to popular journals including *Midwifery Matters,* and access to **MEDLINE Full Text** search engine for full length studies.
- Access to information and **training on adult education,** preceptor-apprentice relationships, midwifery-specific education resources, as well as **cultural humility and equity in student education**.

Student Rights and Responsibilities

NMI Students have the right:

- to be treated according to behavioral guidelines established by the *MANA Statement of Values and Ethics*.
- to be treated without discrimination on any basis including actual or perceived sex, gender identity, race, color, marital status, ethnic origin, religion, age, sexual orientation, or disability.
- to receive opportunities for clinical midwifery experiences commensurate with previous experience and anticipated program length.
- to self-determination in defining their current learning objectives and goals for acquiring clinical midwifery experience.
- to be excused from clinical duties due to death in the family, a sick family member, or other extenuating circumstances to be fairly negotiated with the preceptor.
- to bathroom and lunch breaks in the course of a workday.
- to be informed of any deficits in their performance as determined by preceptor, with clear guidelines for remediation, as long as this feedback is given privately and not in the presence of clients.
- to give feedback to preceptor regarding any questions or disagreements with preceptor's decisions in caregiving, as long as this feedback is given privately and not in the presence of clients.

Students are required to:

1. Maintain a professional ethic (as defined by the *MANA Statement of Values and Ethics*), upholding instructor and preceptor confidentiality at all times;
2. Agree to participate in conflict resolution, utilizing the program's *Grievance Mechanism* as necessary.

Evaluation Policies

During clinical training, preceptor and student jointly evaluate student progress regarding skills successfully acquired and those requiring further development. **Students and preceptors meet to present and discuss their evaluations twice per year, or more frequently as needed.**

Preceptors evaluate students, students evaluate themselves, and students evaluate their preceptors. There are separate forms for submission for each of these. Reminder messages will be sent to preceptors and students when this is required.

Preceptors may recommend specific course work modules for the student to complete to enhance knowledge and competency as they progress toward mastery of the skills and knowledge necessary for entry-level midwifery practice: these recommendations are shared with the student and the student's Course Work Instructor during each evaluation cycle. Preceptors and Course Work Instructors may also discuss student progress with each other at any time as requested by the preceptor and/or course work instructor in order to best support each student's learning. Faculty are encouraged to suggest revisions in mechanisms for evaluating students when completing the annual NMI program review, provided as an online survey each year by May 5th (International Midwives Day).

Student evaluation of faculty is integral to assessing faculty performance and facilitating an egalitarian learning experience and working relationship. Faculty are expected to demonstrate responsiveness to the feedback and individual learning needs of their students. Should a serious disagreement develop between a student and instructor, both will participate in conflict resolution, either through mediation or the program's **Grievance Mechanism**.

GRIEVANCE MECHANISM

Complaints
We intend that disagreements among students, faculty (including preceptors), and staff be resolved at the most immediate level possible through frank and respectful discussion between the parties concerned. or by informal mediation via NMI staff or faculty members, before commencing a formal written grievance process with NMI. Failing this, student, faculty or staff grievances are heard through the program's Grievance Mechanism.

Discrimination Complaints
If a person ("complainant") believes that they have been discriminated against, they may take any of the following actions if desired:
~ A complainant may choose to attempt informal resolution of complaints of discrimination prior to requesting formal assistance with a discrimination complaint, but is not required to do so. If the complainant feels comfortable, they may choose to inform (either verbally or in writing) the person(s) engaging in discriminatory conduct or communication that the behavior is offensive and must stop.
~ The complainant may request that NMI faculty and/or staff engage in informal actions such as counseling, support, advice, and/or facilitated communication between the complainant and respondent in order to resolve concerns and/or stop the behavior. A complainant or respondent may choose to discontinue efforts at informal resolution and a complainant may make a formal complaint as described below.
~ The complainant may choose at any time to initiate the program's formal Grievance Mechanism (see below)
~ NMI recognizes that the complainant requesting a resolution may or may not wish to be identified. National Midwifery Institute makes every effort to accommodate complainants wishing to remain anonymous, according to the procedure outlined in NMI's Complaint and Grievance policy.

All Other Complaints
If a person ("Complainant") has a complaint, they may take any of the following actions if desired:
~ A Complainant may choose to attempt informal resolution of complaints of prior to requesting formal assistance with a complaint, but is not required to do so. If the complainant feels comfortable, they may choose to attempt to resolve their complaint directly (either verbally or in writing) the person(s) that they have the complaint against ("Respondent").
~ The Complainant may request that NMI faculty and/or staff engage in informal actions such as counseling, support, advice, and/or facilitated communication between the Complainant and Respondent in order to resolve concerns and/or stop the behavior. A Complainant or Respondent may choose to discontinue efforts at informal resolution and a Complainant may choose at any time to initiate the program's formal Grievance Mechanism.
~ NMI recognizes that the complainant requesting a resolution may or may not wish to be identified. National Midwifery Institute makes every effort to accommodate complainants wishing to remain anonymous.

Initiating the Grievance Mechanism
A written complaint is required to initiate the Grievance Mechanism. Any employee, applicant for employment or any student who wishes to make a formal complaint, should make it in writing within 3 months of the latest incident taking place.

The written complaint should contain enough detail to allow an investigation to be initiated, including the following information:
- A description of the specific conduct or activities that constitute the basis of the complaint;
- Details of any informal resolution that has been attempted;
- Any evidence supporting the allegations made, e.g. emails;
- Names of any employees, students, faculty or preceptors who may be approached to provide evidence of the alleged unacceptable behavior;
- The name and contact information for the person making the complaint or a statement indicating the complaint is being made anonymously. If the complaint is being made anonymously, NMI still requires a mailing address or email address so that requests for additional information can be made. Complaints submitted anonymously that do not include any means of contact information will not be processed. Every effort will be made to keep the Complainant's identity and mailing address/email address confidential.

Complaints may be submitted by email or postal mail, to any or all of the addresses below. If the Respondent is one of the Program Co-Directors, complaint may be addressed to the second Program Co-Director. If both Program Co-Directors are named in the complaint, Complaint may be sent to the attention of Program Administrator:

Elizabeth Davis, Program Co-Director
elizabeth@nationalmidwiferyinstitute.com

Erin Ryan, Program Co-Director
erin@nationalmidwiferyinstitute.com

Lauren Bruno, Program Administrator
nmioffice@nationalmidwiferyinstitute.com

National Midwifery Institute
PO Box 128
Bristol VT 05443.

This initiates the program's formal Grievance Mechanism.

Grievance Mechanism
Once a written complaint has been registered, the parties named in the complaint are notified by the Program Director*. The Grievance Mechanism Hearing is enacted at least after a 7-day mandatory cooling off period and no more than 30 days from receipt of written complaint. This keeps disagreements within the program and upholds client well being. The Program Director appoints a Grievance Committee of two individuals who may be: members of the faculty; members of the administration; members of the Advisory Board; members of the student body, or; outside community members agreed upon by all parties. Neither of these individuals may be directly involved with the grievance issue(s) or participants. The Program Director may reassign a seat on the committee to either another faculty member, student, or staff member to ensure the philosophy and objectives of National Midwifery Institute are represented during the Grievance Mechanism.
*No individuals involved in the Grievance Mechanism process may be directly involved with the grievance issue(s) or participants. If a Program Co-Director is named in the complaint, the other Program Co-Director will oversee the Grievance Mechanism. If both Program Co-Directors are named in the complaint, then an Advisory Board member will oversee the Grievance Mechanism.

1. Before the Grievance Mechanism Hearing all individuals involved in the grievance must submit written statements outlining the nature of the conflict and all reconciliation efforts. Statements from peer mediators and any other documented reconciliation attempts must be included at the time of the hearing request.
2. The Grievance Committee shall review all documentation surrounding the grievance and at its discretion call upon any individuals involved for clarification and/or information to complete its review of the conflict. The Grievance Committee privately discusses the grievance and makes a decision. The program's Philosophy and Purpose Statement, MANA's Values and Ethics Statement and, in the case of preceptor/ student disagreement, their Informed Consent document and the Preceptor Agreement, shall provide the context for all decision making.
3. The Grievance Committee shall submit in writing to all parties involved a Grievance Resolution Agreement. This outlines specific responsibilities, consequences, time limitations, etc. for an equitable resolution to the grievance. The Grievance Resolution Agreement is the last, best attempt at reconciliation and all individuals requesting a meeting of the Grievance Committee agree to abide by the Grievance Resolution Agreement.

In the case of a seriously offensive incident, NMI may pursue further disciplinary action against any or all parties named in the grievance. Pursuing disciplinary action is determined with a hearing involving the alleged violator, faculty members and may include the NMI Advisory Board.

The outcome of all written complaints and resolutions shall be kept in a separate administration file. Copies of individual complaint records shall be included in the personal files of both parties. Records of complaints are considered permanent records and are maintained in electronic format indefinitely. The details and outcome of all complaints shall remain confidential.
All activities of the Grievance Committee are held confidential and individuals are not discriminated against as a consequence of making a complaint.

Relationship between Complaint Procedures and Disciplinary Actions
Facts gathered and any findings made during the resolution process may be sufficient to obligate the school to take disciplinary action against a faculty member, staff member or student, or for the school to initiate a criminal investigation.

For violations which involve inappropriate behavior or actions, disciplinary actions may include: an oral warning, written warning, removal from public forums, suspension, dismissal from the program, or termination of employment. Pursuing disciplinary action is determined with a hearing involving the alleged violator, faculty members and may include the NMI Advisory Board.

If a criminal investigation is deemed necessary, a National Midwifery Institute co-director may notify the appropriate authorities. To whatever extent is permissible by law, those conducting a criminal investigation and NMI staff conducting a discrimination investigation on the case will agree to cooperate.

Non-Retaliation Policy
The initiation of a complaint by informal or formal procedure may not cause any reflection on the reporting party nor may it affect their future business dealings with the school, their employment, compensation or work assignments or, in the case of students, academic status, or other matters pertaining to their status with the school.

National Midwifery Institute strictly prohibits retaliation against any member of its community for reporting or inquiring in good faith about activity or conduct that the member believes to be wrongful or unlawful activity, or for participating in an investigation or proceeding related to such activity. The School considers such reporting, inquiring, or participating to be protected activities in which all members of the School's community may freely engage. The School is committed to operating with fairness and integrity and expects members of its community to act legally, honestly, and ethically. The purpose of this Policy is to promote an academic and work environment that encourages community members to report any activity they believe in good faith to be wrongful or unlawful. This Policy applies to all members of the School's community, including applicants, students, academic and clinical faculty (preceptors), and staff.

DEFINITIONS

In good faith: done with honest belief that wrongful or unlawful activity may have occurred.

Materially adverse: sufficiently harmful to deter a reasonable person from engaging in protected activities. Protected activities: include (i) reporting (whether internally or externally) or inquiring, in good faith, about suspected wrongful or unlawful activity; (ii) assisting others in making such a report; or (iii) participating in an investigation or proceeding related to suspected wrongful or unlawful activity.

Retaliation: an action, performed directly or through others, that is aimed to deter a reasonable person from engaging in a protected activity or is done in retribution for engaging in a protected activity. Retaliation can take many forms, as described in Section II below. Action in response to a protected activity is not retaliatory unless (i) it has a materially adverse effect on the working, academic, or other School-related environment of an individual; and (ii) it would not have occurred in the absence of the protected activity.

Wrongful or unlawful activity: activity of a community member that violates the law, School policy, or professional standards of conduct, including the laws, policies, and standards referenced in Section I below.

Encouragement of Reporting; Reporting Obligation

Applicable law mandates the reporting of certain unlawful activity. The School is firmly committed to a policy of encouraging timely disclosure of such concerns and prohibits retaliation against any member of the School's community who, in good faith, reports such concerns. The School encourages members of its community to report all information regarding any activity they reasonably believe to be wrongful or unlawful, including activities that may constitute:

1. discrimination, harassment, or sexual misconduct;
2. fraud;
3. unethical business conduct;
4. academic misconduct;
5. fraud, waste, abuse, or mismanagement in connection with student aid;
6. circumstances of substantial, specific, or imminent danger to faculty, staff, or students or the public's health and/or safety;
7. suspected child abuse and/or neglect;
8. other violations of the School's policies or procedures; or
9. other violations of local, state, or federal laws or regulations.

Protection from Retaliation

Members of the community are prohibited from engaging in retaliation as defined above. Examples of materially adverse actions that could constitute retaliation include, but are not limited to:

1. reducing one's salary;
2. giving a negative performance evaluation;
3. decisions relating to one's work assignments, vacation, or promotion or advancement opportunities (whether employment-related or academic);
4. terminating employment;
5. dismissing a student from the School;
6. reducing a student's grade;
7. removing one from a student organization, academic program, or clinical placement;
8. interfering with one's job search;
9. engaging in harassing conduct that is sufficiently severe, pervasive, and/or persistent to create a hostile environment; for this purpose, the existence of a hostile environment is to be judged both objectively (meaning a reasonable person would find the environment hostile) and subjectively (meaning the affected individual felt the environment was hostile); or
10. threats to engage in any of the actions listed above.

No community member may be retaliated against for refusing to carry out a directive ordering the member to engage in wrongful or unlawful activity.

Reporting and Investigation Process

A. Reporting

1. Members of the School's community may report evidence of suspected wrongful or unlawful activity by contacting one or more of (i) the reporter's immediate supervisor, program director, or administrative head, (ii) NMI's Clinical Director; (iii) either of NMI's Program Co-Directors / Educational Co-Directors ; or (iv) NMI's Program Administrator. The reporter chooses which individual or office in this list to whom to report. Any instances of suspected retaliation may be reported in the same manner.
2. The School's community members who prefer to report anonymously may do so by emailing NMI's complaint report email address at reporting@nationalmidwiferyinstitute.com or by postal mail to ATTN: Complaint, National Midwifery Institute, PO Box 128, Bristol VT 05443
3. Reports should be made as promptly as possible after the suspected wrongful or unlawful activity (or retaliation) occurs in order to facilitate investigation of the report. All reports will be handled as promptly and discreetly as possible, with facts made available only to those who need to know to investigate and resolve the matter. If the complaint is being made anonymously, NMI still requires a mailing address or email address so that requests for additional information can be made. Complaints submitted anonymously that do not include any means of contact information will not be processed. Complaints made without providing the above information will not be processed.

B. Investigation

1. In situations where the suspected wrongful or unlawful activity (or retaliation) occurred outside of the context of a School program or activity, or where the respondent is not a member of the School community (including where the respondent has graduated or left the School), the School typically will not conduct an investigation. However, in such situations the School may still address the situation and provide resources to affected individuals within 60 days.
2. The School will consider community members' rights to free expression and academic freedom when investigating reports of wrongful or unlawful activity (or reports of retaliation) that involve an individual's statements or other expression.

Consequences of Violating this Policy

Individuals who are found to have engaged in retaliation as defined above may be subject to discipline under the School's policies and procedures. Disciplinary actions may include: Disciplinary actions may include: an oral warning, written warning, removal from public forums, suspension, dismissal from the program, or termination of employment. Pursuing disciplinary action is determined with a hearing involving the alleged violator, faculty members and may include the NMI Advisory Board.Retaliatory actions taken in violation of law could also subject the individual found to have engaged in retaliation to legal liability.

If you feel that your complaints were not resolved adequately by National Midwifery Institute, please direct your concerns to:

MEAC – Midwifery Education Accreditation Council
1935 Pauline Blvd, Suite 100B, Ann Arbor, MI 48103 (360) 466-208

Clinical Experience Requirements

In order for students to graduate from National Midwifery Institute, they must complete, and seek verifying signatures on:

Functioning in any role (observer, doula, family member, friend, beginning apprentice):
- *10 Observe Births*

Functioning in the role of student-assistant midwife under preceptor supervision:
- *20 Assist Births*
- *22 Assist Prenatal exams*
- *3 Assist Initial exams*
- *20 Assist Newborn exams*
- *10 Assist Postpartum exams*

Functioning in the role of student-primary midwife under preceptor supervision:
- *25 Births attended*
- *75 Prenatal exams*
- *20 Initial exams*
- *20 Newborn exams*
- *40 Postpartum exams between 24hrs and 6 weeks postpartum*

Of the 25 required Student-Primary under Supervision births:
- **10** must be with clients for whom the apprentice provided **Continuity of Care**, with *at least 1 prenatal exam in a student-primary or student-assisting role; and birth*.
- an additional **5** must be with clients for whom the apprentice provided **Full Continuity of Care,** with at least:
    - *5 prenatal visits spanning two trimesters;*
    - *Birth;*
    - *1 newborn exam performed within 12 hours of the birth, and;*
    - *2 postpartum exams occurring between 24 hours and 6 weeks following the birth*

Notes

All Student-Assist prenatal exams, newborn exams, and postpartum exams must be completed before beginning the same categories of clinicals as student-primary midwife under preceptor supervision.

18 Student-Assist births must be completed before beginning Student-Primary under Preceptor Supervision births, or more at the discretion of the supervising preceptor. All 20 need to be documented as completed before graduation.

A minimum of **5** home births must be attended in any role.

A minimum of **2** planned hospital births must be attended in any role.

Transports to the hospital from an out-of-hospital setting are limited to *4 out of the 20 Student-Assistant under Preceptor Supervision births* and *3 out of the 25 Student-Primary under Preceptor Supervision births*: the first 20 Student-Primary under Preceptor Supervision births may include 2 transports, and the remaining 5 Student-Primary under Preceptor Supervision births may include 1 transport.

10 out-of-hospital Student-Primary under Preceptor Supervision births must occur within the last **3 years** from NARM application date and graduation.

All required minimum clinical experience must occur within the last **10 years** from NARM application date and graduation.

A minimum of **10** of the 25 Student-Primary Under Preceptor Supervision births must be attended i**n the US or Canada** and must occur in **out-of-hospital settings**.

NARM requires that the clinical component of a student's midwifery education must be at least two years in duration. California Midwifery Practice Act requires for licensure: a program that is 84 semester units in length, with half of the program consisting of clinical practice (84 semester units equates to 3780 total contact hours, with half being 1890 clinical contact hours.) NMI requires a minimum student enrollment period of twelve months, provided that the student meets the NARM two-year clinical timeframe stated above.

These clinical experiences are sufficient to meet NARM certification standards for entry-level midwifery practice, California licensing requirements as well as the licensing requirements of many states. Students are responsible for knowing the requirements of their own states.

Although students are encouraged to seek continuity of training by working primarily with one preceptor, a student may have any number of qualified preceptors. Students attending births with a new preceptor and with prior birth experience sufficient to begin student-primary care under preceptor supervision may be required to attend births as an observer or assistant before beginning student-primary care under preceptor supervision.

Students are required to use client codes (not names) on all experience documentation. Clinical experience documentation with client names will be returned to the student for resubmission.

Phases of Clinical Experiences

Midwifery students typically divide their clinical experiences and clinical experience documentation into three distinct phases, as required by the North American Registry of Midwives (NARM):

1) **Observe:** students are active observers at a birth, or supporting in a doula-type role. Students are not performing clinical skills.

   - some students complete these observe experiences prior to enrolling with NMI, during their previous birth support or doula work
   - these births need to be signed/acknowledged by a witness, but this witness does not need to be a registered preceptor, it can be anyone present at the birth with the student

2) **Assist:** students are actively engaged in the clinical experience (prenatal visit, family planning visit, birth, postpartum visit, other types of client interactions), and assisting the midwife in all essential tasks and skills. Students are learning to perform clinical skills.

   - students may act as a birth assistant or back-up midwife at births when a midwife feels they are competent. This may include proficiency in emergency skills if assistance is needed, charting, vital signs, fetal heart rate, etc.
   - catching a baby is usually a skill learned during the assist phase, starting with four-handed catches, and progressing until proficiency and independence in the Primary Under Supervision Phase
   - generally, students are able to learn and eventually complete basic clinical skills, but not yet able to manage/run a whole appointment or birth independently

3) **Primary Under Supervision:** students are competent and proficient at managing client interactions and performing clinical skills independently. The precepting midwife supports and supervises from the sidelines.

   - students should function as if they are the midwife, and demonstrate independent skills. Clients should perceive them as their equal or primary midwife.
   - students demonstrate proficiency not just in clinical skills, but in planning ahead, documenting and charting, restocking supplies, etc.
   - preceptors still support students and clients when new situations present, more information or wisdom is needed, or emergencies need intervention.

Effective Preceptorship

Precepting a midwifery student can be a fulfilling commitment. Not only are you helping shape a new midwife, but you are adding to the midwifery community, and to the available providers for reproductive health in the broader community. This is critically important in this time (and all times). Over time, you can also hope that as a midwifery student grows in competence and indolence, they may lighten some of the load at your practice, and support your clients even more deeply.

In order to be an effective, fair, and productive preceptor, you are encouraged to consider the following offerings to students, and what your capacity is to meet each one. Be clear with your students on what you can and cannot offer, and what you believe them to be ready for, or not ready for:

- Students should be provided an in-depth orientation to the practice upon starting an apprenticeship. This should include, but is not limited to: *midwife schedules, clinic days, home visit appointments, charting and filing practices or software, clinical equipment, referral chains, communication expectations and methods, services offered and not offered, student roles and expectations, evaluation protocols, a full clinical site orientation, and any other details deemed pertinent by the student and/or preceptor.*
- Allow students to progress between Observe / Assist / Primary-Under-Supervision phases as appropriate to student capacity and demonstrated skill level, as well as client input and midwife willingness. *If you are only able to precept students until or after a certain point in this progression, be up front with students about this limitation when they join your practice.*
- Assist students in developing critical thinking in midwifery care, including diagnosing and treating clients and babies as necessary, learning alternative treatments and remedies, as well as referral pathways and when outside help is required.
- Introduce students to clinical skills at an appropriate rate, and work withs students to hone skills and exhibit competence and mastery over time. Allow students space and time to develop their own techniques and try skills in more than one way, and to demonstrate their skills to you for appropriate sign-offs when ready. *Students are encouraged to practice skills on people other than clients before working with clients, and encouraged to attend skills workshops wherever possible.*
- Guide students through the processes of midwifery business administration, including booking clients, processing payments (or working with a billing team), ordering supplies, keeping and maintaining records, etc.
- Help students learn about midwifery charting and record keeping, including the essential elements of a chart, charting as a legal document, drafting and signing consent paperwork, documenting their presence, and the use of paper or electronic charting *depending upon the preceptor's preference or established systems.*

- Provide students with a list of required and recommended supplies they must carry to appointments and births, and make clear what disposable supplies you can/can't provide in your practice, and which are the responsibility of the student.
- Demonstrate your thought processes and include students in individual care-plan making and case management. In addition, review appropriate cases with students and brings students to Peer Review when possible so they can continue to learn from the community.
- Provide students with regular, constructive feedback, at least as frequently as the required quarterly evaluations with NMI. Students may learn quicker with more frequent feedback directly after experiences.
- Help students build confidence as independent midwives by giving them increasing responsibility, supervision in making care plans, and asking their opinion when appropriate.
- Understand the basic structure of NMI, NMI Preceptor Rights and Responsibilities, NMI Student Rights and Responsibilities, and Clinical experience Documentation expectations for NMI students and support their clinical education.
- Promptly sign off on clinical experiences and skills you personally witness and agree are complete and competent. *It is the student's responsibility to arrange a time and be organized in presenting their paperwork for signature. The preceptor is not expected to withhold signatures where inappropriate. When this is contested, both parties can discuss this with NMI's Clinical Director.*
- Be familiar with the NARM Requirements and expectations of preceptors, as well as the educational and clinical requirements to become a CPM.
- Maintain workplace safety compliance (including FERPA, HIPPA, OSHA, and any local regulations and mandates).
- Maintain emotional and mental safety for students, allowing space and time for them to develop skills in an environment free of verbal, emotional, or cultural abuse or violence. *See NMI Student Rights and Responsibilities*
- Bring personal awareness and growth to relationships with students *especially to students of marginalized communities and communities different from your own, including but not limited to students marginalized by their race, class, ability, as well as LGBTQ+, and trans students.* Commit to fostering relationships with your students from a place of cultural humility equity. For more resources on these topics, visit the *Resources* section on the NMI Preceptor Portal on our website, or reach out to our Clinical Director.

ENGAGING STUDENTS

NMI students are adult learners, and the principles of adult education differ from that of children's education. We respect that these students are mature, responsible, and know their own strengths and weaknesses. Due to the self-directed nature of NMI's education, students typically have a high level of personal organization and awareness of their needs. In order to best engage with students, we have provided some suggestions below.

In order to best foster…	**...consider trying some of the following approaches**
curiosity in a student	• encourage asking questions with thoughtful guidance to answers • help students see where you look for answers to questions • pose case studies for students so they can research issues without an urgent deadline (as in direct client care questions) • use a variety of teaching styles (visual, written, auditory, practical)
trust between a student and preceptor	• practice professional communication, even and especially when frustrated with student actions or performance • provide fair, reasonable feedback with clear tasks for improvement, and positive feedback when improvement is evident • honor student experience and ideas and incorporate helpful contributions of students into your practice
trust between your clients and your student	• introduce students and their roles clearly • allow space for students to speak and offer help to clients as appropriate • allow extra time to involve students in decision making and care plans • allow space for clients to decline working with students if they prefer
direction and goals in a student	• encourage students to make a collaborative learning plan with you • be familiar with graduation requirements from NMI and NARM licensing requirements and the goal points to achieving them • help students explore areas of competence outside their curriculum and community-specific competencies
confidence in a student	• allow increasing responsibility with clients and space for decision making • have students talk you through their thought processes and explain rationale, add suggestions as you see fit • allow growing independence as students rise to the occasion
critical thinking and reflection in a student	• allow students to attend Peer Review with you and encourage their participation where appropriate • have students present case studies on topics to you or to Peer Review • elicit regular self-reflection from students

TEACHING METHODS

Midwifery students as adult learners respond to a variety of teaching methods and roles from their preceptor. Not every method will work for everyone, and the same student may need different methods at different times. This is by no means a comprehensive list, but is meant to elicit reflection from preceptors as to the different roles they might play with their students.

Teaching Method	Examples
Planning	• setting regular/weekly checklists and tasks, as well as regular check-ins • crafting checklists for what to discuss at each client visit • prepping client charts and reviewing charts on discharge, entering statistics such as MANA stats or local/regional data tracking
Demonstrating	• walking students through a clinical skill in private, then later on a client (with client consent) • talking through a skill as you perform it so a student can hear your thought processes and hear critical thinking
Supporting	• encourages students to build self confidence by giving appropriate amounts of increasing responsibility • providing positive reinforcement and praise when appropriate
Facilitating	• staying in the background at a birth while the student manages key aspects, offering support as a back-up midwife would •
Guiding	• Sharing books and research resources when students express curiosity • engaging in problem-based learning, collaboratively finding solutions • using three-way calling wit students and clients to have students answer client questions under your supervision
Role Modeling	• having students accompany you to community events and activist opportunities, including political advocacy or midwifery organization work • conducting yourself professionally during transfers to hospital, consultations, and other engagements with interprofessional colleagues
Reinforcing	• helping students gain muscle memory and confidence by repeating skills over and over until demonstrating mastery • incorporating student feedback into your teaching styles • incorporating student contributions into your practice

ADULT EDUCATION

Learning and demonstrating some basic principles of adult education can go a long way in fostering a health learning environment for students. Effective, clear communication of expectations, as well as intentional strategies in teaching are key elements in the preceptor-student relationship. Excellent preceptors don't just go about their days in their practice with a student shadow, but actively teach the student in as many moments as possible. Every moment is a teaching moment in midwifery!

Learning is understood as a process:

- Learning is an active and continuous process manifested by personal and clinical growth and changes in behavior
- Learning styles and expected progress vary from one individual to another
- Learning is dependent on the readiness, emotional state, abilities and potential of the learner, as well as their life experiences. Learning is also dependent on the skill of the preceptor and their openness to facilitating student growth
- Learning is facilitated when the student has an opportunity to show independence, test ideas, analyze mistakes, take risks and be creative
- Learning is facilitated when the learner has feedback of his/her progress toward their goals
- Interpersonal relationships are important in determining the kind of social, emotional and intellectual behavior that emerges in the learning situation
- Recognition of similarities and differences between past and current experience facilitates the transfer of learning

adapted from Colombia School of Nursing

Adults are best motivated to learn when:

- the learning is practical, and directly relevant to their lives
- they personally want to learn the material or skills and are internally motivated
- the learning is informal
- the learning is self-directed and not micro-managed
- they perceive preceptors/instructors to be personally invested in the material, in themselves as learners, and in the development of the field
- they are given space to contribute something new or novel
- they receive positive reinforcement when demonstrating competence and gentle constructive feedback when learning and not yet performing adequately

GIVING FEEDBACK

One fundamental aspect to the preceptor-student relationship is giving regular feedback. Midwifery students expect to receive regular feedback to work towards their goals, build confidence, increase their competence with clients over time. Students require both positive and constructive feedback. Preceptors should provide frequent, specific feedback on students' knowledge, skills, and abilities and identify their strengths and weaknesses so students will know what they can do to improve. Giving excessive, insufficient or negative feedback can result in conflict between you and the student, and can have a negative effect on learning and on the preceptor-student relationship as a whole. Effective preceptors are honest and direct with students about their performance, notice when they perform well, and provide specific suggestions for improvement.

Tips for giving Helpful Feedback:

- Daily feedback in a private location generally helps the student to feel secure
- Give feedback in a private place. Adhere to the adage, "praise in public, correct in private." If it is necessary to correct a student in front of colleagues or clients, do it in a tactful way
- Ask students to evaluate themselves after tasks are performed by asking, "How do you feel you did?" and "What could you do differently next time?" This initiates performance evaluation in a non-threatening manner
- Feedback should be objective in nature. Use "I" statements, such as, "I noticed that…" Avoid judgmental statements, such as "You should have known better…"
- Private weekly evaluations work well to track student progress towards course and personal objectives. This is the time to say, "You are doing well." Point out what the student has learned and how much knowledge and skill proficiency has been acquired and what problems need to be addressed. NMI requires quarterly written evaluations/ reflections
- Phrase feedback in a positive fashion, such as "This is what I want you to work on."
- Encourage students by pointing out their strengths often and in an honest manner. Celebrate successes together
- Preceptors should also welcome ongoing feedback regarding the preceptorship process. Asking "How am I doing?" opens communication up so students can share their needs and experiences. It is also a good opportunity for the preceptor to model appropriate behavior when receiving constructive criticism. Students are also expected to review their preceptor on a quarterly basis with NMI

adapted from Public Health Ontario

STUDENT PROGRESS

Midwifery students typically divide their clinical experiences into three distinct categories: *Observe, Assist,* and *Primary Under Supervision.* At each one of these phases, students are likely to experience learning curves and support from their preceptors. Steps for observing and eventually evaluating student progress may look like the following:

1. The student observes the preceptor carrying out daily work. Before beginning a task, question the student to find out how much they know about this task or the context or background around it and to help the student understand associated responsibilities. After finishing the task, prompt the student to reflect on the experience. For example, a preceptor may ask how the student might have handled the task differently.

2. The student assists the preceptor by performing a small portion of a task or procedure. Before a student carries out a new procedure, ask them to demonstrate and/or explain the steps involved. Watching procedures, in addition to performing assigned duties is a valuable combination.

3. The preceptor observes the student completing specific tasks. Direct observation is important in establishing a learning climate, reinforcing skills, and stimulating independent performance. After the student completes a task, reinforce appropriate behavior and provide constructive feedback. As the student becomes proficient and comfortable in skill development, add to the assigned duties. Be sure the student knows what parts of the task they can perform. Give opportunity for repetition of skills and practice. Repeating skills helps the student to become more comfortable and confident. An important responsibility of preceptors is determining when a student is ready to be more independent. In deciding when to “let go”, take into consideration whether:
    - both the student and preceptor are comfortable with the student making decisions,
    - the student has demonstrated they can perform without making mistakes, transfers learning to new situations, recognizes the limits of their knowledge, and adapts to schedule changes
    - the student asks/articulates that they are ready to perform tasks alone and are ready for more challenging experiences.

4. The student performs independently and provides regular reports to the preceptor. Evaluate the student’s performance at this stage by reviewing outcomes of student actions.

adapted from Public Health Ontario

Ethics in Preceptorship

Because the preceptor-student relationship is so personal in nature, and because it is largely managed by the preceptor and student themselves, it is critical to approach this relationship from a place of ethical behavior. While articulated in NMI policies and elsewhere in the handbook, certain principles bear repeating for consideration:

- **Equity in Relationship:** give careful consideration to the power differential between preceptors and students. Use your power as a preceptor ethically and justly. For example, s*tudents should not be asked to do administrative or cleaning tasks unrelated to client care. Signatures should not be withheld on student paperwork for personal punishment. Bullying and harassment will not be tolerated. Students should be treated with respect at all times.*

- **Compensation:** preceptors with NMI are compensated modestly from student tuition for clinical experience, though preceptors may waive these payments and make other arrangements with their students. *Some preceptors compensate students once they are in Primary-Under-Supervision phase, as they would any other assistant. Students tend to work longer, harder hours than even their preceptors, pay for their education, and go unpaid for years of work. This is understandably challenging and presents barriers to midwifery education. Consider how you may work to shift this environment.*

- **Mutual Respect:** preceptors and students should be accommodating of each others' needs, work to value and respect each other in public and in private, and respect each others' relationship with clients.

- **Discrimination:** NMI will not tolerate any acts of discrimination towards precepts or students based upon race, class, gender, gender expression, ability, LGBTQ+ identification, or other personal characteristics and identities.

- **Involving Students in Client Care:** Clients should always be aware of the present of students the status of these students, and the expected role these students will play in their care. Clients should also be informed whether or not working with students or having students practice clinical skills on them is mandatory or optional as a part of their care with you. Ideally, clients should have the right and ability to decline student involvement in their care. Students must learn not to take this personally.

APPENDIX

Statement of Values and Ethics

Revised and approved August, 2010

Statement of Values

The Statement of Values and Ethics of the Midwives Alliance of North America (MANA) is a critical reflection of moral issues as they pertain to maternal and child health. It is intended to provide guidance for professional conduct in the practice of midwifery, as well as influence MANA's organizational policies, thereby promoting high-quality care for childbearing families.

Since what we value infuses and informs our ethical decisions and actions, the Midwives Alliance of North America affirms:

I. Woman As a Unique Individual:

A. We value each woman as a strong, creative, unique individual with life-giving powers.
B. We value each woman's right to a supportive caregiver appropriate to her needs and respectful of her belief system.
C. We value a woman's right to access resources in order to achieve health, happiness and personal growth according to her needs, perceptions and goals.
D. We value a woman as autonomous and competent to make decisions regarding all aspects of her life.
E. We value the empowerment of a woman during the processes of pregnancy, birth, breastfeeding, mother–infant attachment and parenting.

II. Mother and Baby as Whole:

A. We value the mother and her baby as an inseparable and interdependent whole and acknowledge that each woman and baby have parameters of well-being unique to themselves.
B. We value the physical, psychosocial and spiritual health, well-being and safety of every mother and baby.
C. We value the mother as the direct care provider for her unborn child.
D. We value the process of labor and birth as a rite of passage with mother and baby as equal participants.
E. We value the sentient and sensitive nature of the newborn and affirm every baby's right to a caring and loving birth without separation from mother and family.
F. We value breastfeeding as the ideal way to nourish and nurture the newborn.

III. The Nature of Birth:

A. We value the essential mystery of birth.
B. We value pregnancy and birth as natural, physiologic and holistic processes that technology will never supplant.
C. We value the integrity of a woman's body, the inherent rhythm of each woman's labor and the right of each mother and baby to be supported in their efforts to achieve a natural, spontaneous vaginal birth.
D. We value birth as a personal, intimate, internal, sexual and social experience to be shared in the environment and with the attendants a woman chooses.
E. We value the right of a woman and her partner to determine the most healing course of action when difficult situations arise.
F. We value the art of letting go and acknowledge death and loss as possible outcomes of pregnancy and birth.

IV. The Art of Midwifery:

A. We value our right to practice the art of midwifery, an ancient vocation of women.
B. We value multiple routes of midwifery education and the essential importance of apprenticeship training.
C. We value the wisdom of midwifery, an expertise that incorporates theoretical and embodied knowledge, clinical skills, deep listening, intuitive judgment, spiritual awareness and personal experience.
D. We value the art of nurturing the inherent normalcy of pregnancy and birth as expressions of wellness in a healthy woman.
E. We value continuity of care throughout the childbearing year.

F. We value birth with a midwife in any setting that a woman chooses.
G. We value homebirth with a midwife as a wise and safe choice for healthy families.
H. We value caring for a woman to the best of our ability without prejudice with regards to age, race, ethnicity, religion, education, culture, sexual orientation, gender identification, physical abilities or socioeconomic background.
I. We value the art of empowering women, supporting each to birth unhindered and confident in her natural abilities.
J. We value the acquisition and use of skills that identify and guide a complicated pregnancy or birth to move toward greater well-being and be brought to the most healing conclusion possible.
K. We value standing up for what we believe in the face of social pressure and political oppression.

V. Woman as Mother:

A. We value a mother's intuitive knowledge and innate ability to nurture herself, her unborn baby and her newborn baby.
B. We value the power and beauty of a woman's body as it grows in pregnancy and a woman's strength in labor and birth.
C. We value pregnancy and birth as processes that have lifelong impact on a woman's self-esteem, her health, her ability to nurture and her personal growth.
D. We value the capacity of partners, family and community to support a woman in all aspects of pregnancy, birth and mothering and to provide a safe environment for mother and baby.

VI. The Nature of Relationship:

A. We value an egalitarian relationship between a woman and her midwife.
B. We value the quality, integrity and uniqueness of our interactions, which inform our choices and decisions.
C. We value mutual trust, honesty and respect.
D. We value a woman's right to privacy, and we honor the confidentiality of all personal interactions and health records.
E. We value direct access to information that is readily understood by all.
F. We value personal responsibility and the right of a woman to make decisions regarding what she deems best for herself, her baby and her family, using both informed consent and informed refusal.
G. We value our relationship to a process that is larger than ourselves, recognizing that birth is something we can seek to learn from and to know, but cannot control.
H. We value humility and the recognition of our own limitations.
I. We value sharing information and understanding about birth experiences, skills and knowledge.
J. We value a supportive midwifery community as an essential place of learning.
K. We value diversity among midwives that broadens our collective resources and challenges us to work toward greater understanding.
L. We value collaboration between a midwife and other health-care practitioners as essential to providing a family with resources to make responsible and informed choices.
M. We value the right and responsibility of both a midwife and a woman to discontinue care when insurmountable obstacles develop that compromise communication, mutual trust or joint decision making.
N. We value the responsibility of a midwife to consult with other health-care practitioners when appropriate and refer or transfer care when necessary.

VII. Cultural Sensitivity, Competency and Humility

A. We value cultural sensitivity, competency and humility as critical skills for the midwife to master in an increasingly multicultural society.
B. We value cultural sensitivity—a midwife's awareness of and ability to honor differences between people and the cultural values of the women she serves.
C. We value the importance of cultural competency in addressing the social and economic barriers to access to care for vulnerable, underserved and marginalized women, thereby improving maternal and infant health and the well-being of families.
D. We value cultural humility as a lifelong process of self-reflection and self-critique in order to develop a respectful partnership with each woman.*

*Section VII is derived from Melanie Tervalon and Jann Murray-Garcia, "Cultural Humility versus Cultural Competency: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education," Journal of Health Care for the Poor and Underserved 9 (May 1998): 117–25.

Statement of Ethics

Our values inform and inspire midwifery practice in our hearts and minds. Acting ethically is an expression of our values within the context of our individual, geographic, religious, cultural, ethnic, political, educational and personal backgrounds and in our relationships with others. As we seek to respond in the moment to each situation we face, we call upon ethical principles of human interaction as follows:

- Beneficence—to act so as to benefit others
- Nonmaleficence—to avoid causing harm
- Confidentiality—to honor others' privacy and keep personal interactions confidential
- Justice—to treat people respectfully and equitably
- Autonomy—to respect an individual's rights to self-determination and freedom to make decisions that affect his or her life.

The equality and mutuality of the relationship between midwife and client create a foundation uniquely suited to integrate these principles. As midwives, we seek to benefit women and babies in our care. Mutual trust and respect are critical to the success of a relationship that requires joint decision making at every level. Moral integrity, truthfulness and adequate information enable all participants to judge together the best course of action in varied situations.

Judgments are fundamentally based on awareness and understanding of ourselves and others. They grow out of our own sense of moral integrity, which is born within the heart of each individual. Becoming self-aware and increasing understanding are ongoing processes that must be nurtured as a function of personal and professional growth. MANA's affirmation of individual moral integrity and recognition of the complexity of life events bring us to an understanding that there cannot possibly be one right answer for all situations. Since the outcome of pregnancy is ultimately unknown and is always unknowable, it is inevitable that in certain circumstances our best decisions in the moment will lead to consequences we could not foresee.

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We recognize the limitations of traditional codes of ethics that present a list of rules to be followed. Therefore, a midwife must develop a moral compass to guide practice in diverse situations that arise from the uniqueness of pregnancy and birth as well as the relationship between midwives and birthing women. This approach affirms the mystery and potential for transformation present in every experience and fosters truly diverse practice. Midwifery care is woman-led care with informed choice and a clear set of values at its core. Decision making is a shared responsibility with the goals of healthy women and babies and of gentle, empowering births with a focus on individual and family needs and concerns. Ultimately, it is at the heart of midwifery practice to honor and respect the decisions women make about their pregnancies and births based on their knowledge and belief about what is best for themselves and their babies.

There are both individual and social implications to any decision-making process. Our decisions may be impacted by the oppressive rules and practices of a society that is often hostile to homebirth, midwives and midwifery clients. Our actual choices may be limited by the medical, legal, political, economic, cultural or social climate in which we function. The more our values conflict with those of the dominant culture, the greater the threat to the integrity of our own values, and the greater the risk that our actions may lead to professional repercussions or legal reprisal. In such conditions we may be unable to make peace with any course of action or may feel conflicted about a choice already made. The community of women, both midwives and those we serve, may provide a fruitful resource for continued moral support and guidance.

In summary, acting ethically requires us to define our values, respond to the communities of families, midwives and cultures in which we find ourselves, act in accord with our values to the best of our ability as the situation demands, and engage in ongoing self-examination, evaluation, peer review and professional growth. By carefully describing the multifaceted aspects of what we value and defining the elements of moral integrity and decision making, we have created a framework for ethical behavior in midwifery practice. We welcome an open and ongoing articulation of values and ethics and the evolution of this document.

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Principles of Adult Learning

Prepared by Steve Shorlin, PhD, Teaching Consultant, Medical Education Scholarship Centre.

Adults learn best when the learning:	As a teacher, you can:
Is autonomous and self-directed	• Involve learners in the learning process • Give them opportunity to direct what they need to know • Create educational contracts • Anticipate needs beyond those identified by learners
Is directed towards a goal	• Show learners the big picture from the beginning • Provide clear and specific objectives • Ground learning in practical outcomes
Is relevant and practical	• Base learning around cases and problems from practice • Use real-life teaching situations • Provide examples from your own experience

Acknowledges learner's experience	• Realize that learners have much to contribute to knowledge and skills already
	• Know your audience
	• Assess prior learning by KWL
	  ○ what do you KNOW
	  ○ what do you WANT to know
	  ○ what did you LEARN

Matches learner's style	• Teach in a variety of modes
	  ○ visual, auditory, hands-on
	  ○ active + reflective
	  ○ big picture + steps
	  ○ practical + theory
	  ○ solitary + groups
	• Recognize your own biases

Is active	• Encourage thought and interaction • Ask questions • Hands-on application • Demonstrations
Provides feedback	• Give constant timely feedback • Balance positive with negative • Always be respectful
Takes place respectfully	• Be courteous and patient • Learn and use names • Show value in all contributions

Reference:
Collins, J. (2004). Education techniques for lifelong learning: principles of adult learning. Radiographics, 24(5), 1483-9.
Thanks to Dr. Vernon Curran for providing the original material in a different form.

NARM Policies on Preceptor/Apprentice Relationships

In validating the apprenticeship as a valuable form of education and training for midwifery, NARM appreciates the many variations in the preceptor/apprentice relationship. In upholding the professional demeanor of midwifery, it is important that each party in the relationship strive to maintain a sense of cooperation and respect for one another. While some preceptor/apprentice relationships develop into a professional partnership, others are brief and specifically limited to a defined role for each participant.

Effective January 1, 2017, all NARM preceptors **must be registered before supervising** any clinicals documented on a student's NARM Application. Skills/clinicals signed off after that date by a preceptor who is not registered with NARM will be invalid.

To help NARM candidates achieve exceptional training and a satisfactory relationship from their apprenticeship, NARM makes the following statements:

1. **All preceptors for NARM PEP applicants must be currently registered with NARM as a Registered Preceptor.** Preceptor registration requires filling out and submitting the NARM Preceptor Registration Form 700. Forms may be found at www.narm.org and searching preceptor registration.In order to qualify as a NARM Registered Preceptor, the midwife must document their credential as a Certified Professional Midwife (CPM), Certified Nurse Midwife (CNM), Certified Midwife (CM); or s/he must be a licensed practitioner legally recognized by a state/jurisdiction to provide maternity care. A preceptor must have an additional three years of experience after credentialing or fifty primary births beyond entry-level CPM requirements. Additionally, s/he must also have ten continuity of care births beyond entry-level CPM requirements. A preceptor must have attended a minimum of ten out-of-hospital births in the last three years. Current preceptor registration with NARM is required for clinicals to be valid. **It is the student's responsibility to verify the preceptor's registration status by asking his/her preceptor or contacting NARM.**
2. The clinical components of apprenticeship should include didactic and clinical experience, and the clinical component must be at least two years in duration. The average apprenticeship which includes didactic and clinical training typically lasts three to five years. In the PEP Application, the dates from the earliest clinical documented in Phase 1 or 2 until the last clinical documented in Phase 3 must span at least two years, or the applicant should enclose a statement explaining additional clinical experiences that complete the requirement

but are not charted on these forms. Additional births may also be reflected on Form 102 Birth Experience Background.

3. It is acceptable, even preferable, for the apprentice to study under more than one Registered Preceptor. In the event that more than one preceptor is responsible for the training, each preceptor will sign off on those births and skills which were adequately performed under the supervision of that preceptor. Each preceptor who signs for any clinicals on Forms 111 or 112 must fill out, sign and have notarized the Verification of Birth Experience Form. **All numbers signed for must be equal to or greater than the numbers signed for on Forms 111a-d and 112a-e**. The apprentice should make multiple copies of all blank forms so each preceptor will have a copy to fill out and sign. These forms should be filled out and signed by the preceptor, not the applicant.
4. The preceptor and apprentice should have a clear understanding of the responsibilities of each person to the other, including the time expected to be spent in one-on-one training, classroom or small group study, self-study, clinical observation, opportunities for demonstration of skills, time on call, and financial obligations.
5. The apprentice, if at all possible, should have the NARM application at the beginning of the apprenticeship and should have all relevant documentation signed at the time of the experience rather than waiting until the completion of the apprenticeship.
6. Preceptors are expected to sign the application documentation for the apprentice at the time the skill is performed competently. **Determination of "adequate performance" of the skill is at the discretion of the preceptor, and multiple demonstrations of each skill may be necessary**. Documentation of attendance and performance at births, prenatals, postpartums, etc., should be signed only if the preceptor agrees that expectations have been met. Any misunderstanding regarding expectations for satisfactory completion of experience or skills should be discussed and resolved as soon as possible, however **the preceptor makes the final determination**.
7. The preceptor is expected to provide adequate opportunities for the apprentice to observe clinical skills, to discuss clinical situations away from the clients, to practice clinical skills, and to perform the clinical skills in the capacity of a primary midwife, all while under the direct supervision of the preceptor. This means that **the preceptor must be physically present** when the apprentice performs the midwife skills. The preceptor holds the final responsibility for the safety of the client or baby and should become involved, whenever warranted, in the spirit of positive education and role modeling. Preceptors who sign clinicals but refuse to complete the Final Verification Form without a justifiable reason, risk having their preceptor status revoked. If there is a concern, the clinical skill should not be signed off in the first place.
8. **Preceptors who sign off on experiences they did not witness risk losing their ability to sign as a preceptor in the future and also risk losing their NARM Certified Professional Midwife (CPM) credential.**
9. NARM's definition of the Initial Prenatal Exam includes covering an intake interview, history (medical, gynecological, family) and a physical exam. These exams do not have to occur all on the first visit to the midwife, but the apprentice should perform at least 20 of these exams on one or more early prenatal visits.
10. Prenatal Exams, Newborn Exams, and Postpartum Exams as Assistant Under Supervision (forms 111b-d) must be completed before the same category of clinicals may be verified as Primary Under Supervision (Forms 112 b-e). However, Prenatals, Newborn Exams, and Postpartum Exams as a Primary Under Supervision may begin before the Primary Under Supervision births occur.
11. Births as Assistant Under Supervision (Form 111) are births where the apprentice is being taught to perform the skills of a midwife. Just observing a birth is not considered Assistant Under Supervision. Charting or other skills, providing labor and birth support, and participating in management discussions may all be done as an assistant in increasing degrees of responsibility. The apprentice should perform some skills at every birth listed on Form 111a and must be present throughout labor, birth, and the immediate postpartum period. The

apprentice must complete 18 of the Assistant Under Supervision births before functioning as Primary Under Supervision at births.

12. Births as a Primary Midwife Under Supervision (Form 112) means that the apprentice demonstrates the ability to perform all aspects of midwifery care to the satisfaction of the preceptor who is physically present and supervising the apprentice's performance of skills and decision making.
13. Catching the baby is a skill that should be taught and performed during the Assistant Under Supervision phase. The Primary Under Supervision births require that the student be responsible but under supervision for all skills needed for labor support and monitoring of mother and baby, risk assessment, the delivery of the infant, newborn exam, and the immediate postpartum assessment of mother and baby. If the mother or father is "catching" the baby, the Primary Under Supervision is responsible for all elements of the delivery. If the preceptor catches the baby, then that birth qualifies as Assistant Under Supervision for the student.
14. Attendance at a birth where either the apprentice or preceptor is also the client will not be accepted for verification of the required clinicals.

Contact Us:

NARM Phone and Fax Number

For all Departments
888-842-4784

NARM General Information

Debbie Pulley
5257 Rosestone Dr.
Lilburn, GA 30047
info@narm.org

NARM Applications and Testing Department

PO Box 420
Summertown, TN 38483
applications@narm.org

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Guidelines for Documentation of Clinical Experience

NARM Registered Preceptors who sign off on experiences they did not witness risk losing their ability to sign as a preceptor in the future and also risk losing their CPM certification.

To help NARM candidates achieve exceptional training and a satisfactory relationship from their apprenticeship, NARM makes the following recommendations:

1. The preceptor and apprentice should have a clear understanding of the responsibilities of each person to the other, including the time expected to be spent in one-on-one training, classroom or small group study, self-study, clinical observation, opportunities for demonstration of skills, time on call, and financial obligations.
2. The apprentice, if at all possible, should have the NARM application at the beginning of the apprenticeship, and should have all relevant documentation signed at the time of the experience rather than waiting until the completion of the apprenticeship.

In response to multiple requests for clarification about the role of the NARM Registered Preceptor in the NARM application/certification process, NARM has developed the following guidelines based on the instructions set forth in the Candidate Information Bulletin. These guidelines are recommendations for successful completion of the application documentation.

1. The preceptor and applicant together should:
    a. Review the three (3) separate practice documents required by NARM—Practice Guidelines, Informed Consent, and Emergency Care Form.

    b. Review all client charts (or clinical verification forms from a MEAC accredited program) referenced on the NARM Application and confirm that the preceptor and applicant names/signatures appear on each part of the chart/form that is being referenced.

    c. Confirm that the signatures/initials of the applicant and preceptor are on every chart/form for: initial exam, history and physical exam, complete prenatal exams, labor, birth and immediate postpartum exam, newborn exam, and complete follow-up post partum exams listed on the NARM Application. Be sure the numbers written on the application forms are the same number of signatures/initials for both the applicant and the preceptor on the charts/forms.

d. Check all birth dates and dates of all exams for accuracy.

e. Check all codes to make sure there are no duplicate code numbers. Each client must have their own unique code. If there is more than one birth with any given client, there must be a different code assigned for each subsequent birth.

2. If a preceptor has more than one student (applicant), each chart must have a uniform code that all students will use. Students should not develop different codes for the same client.
3. Preceptors need to be sure their forms show that the student participated as primary under supervision and that the preceptor was present in the room for all items the preceptor signs. For example, the arrival and departure times at the birth should be documented on the chart for both the applicant and the preceptor. At the time of clinical experience, preceptors and students should initial each visit.
4. Applicants should have access to or copies of any charts listed in the application, Form 112a-f and Form 200 with Code in case of audit.

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The North American Registry of Midwives

Certified Professional Midwife (CPM)

NARM Registered Preceptor Handbook

Table of Contents

NARM Registered Preceptor Overview

What is a NARM Registered Preceptor?

A NARM Registered Preceptor is a credentialed, experienced midwife who agrees to train apprentice midwives intending to apply for the Certified Professional Midwife (CPM) credential and has current, approved registration through NARM.

To serve as a preceptor for a CPM applicant, one must:

- Hold a current North American midwifery credential:
  - Certified Professional Midwife (CPM),
  - Certified Nurse Midwife (CNM)/Certified Midwife (CM), or
  - Licensed practitioner legally recognized by the state to provide maternity care.
- Meet at least one of the following criteria:
  - Have at least 3 years of experience beyond entry-level CPM requirements, or
  - Have served as a primary midwife for at least 50 births, including 10 continuity of care births, beyond the entry-level CPM* requirements.
- Have provided continuity of care for at least 10 clients beyond entry-level CPM requirements.
- Have attended a minimum of 10 out-of-hospital births in the last three years.

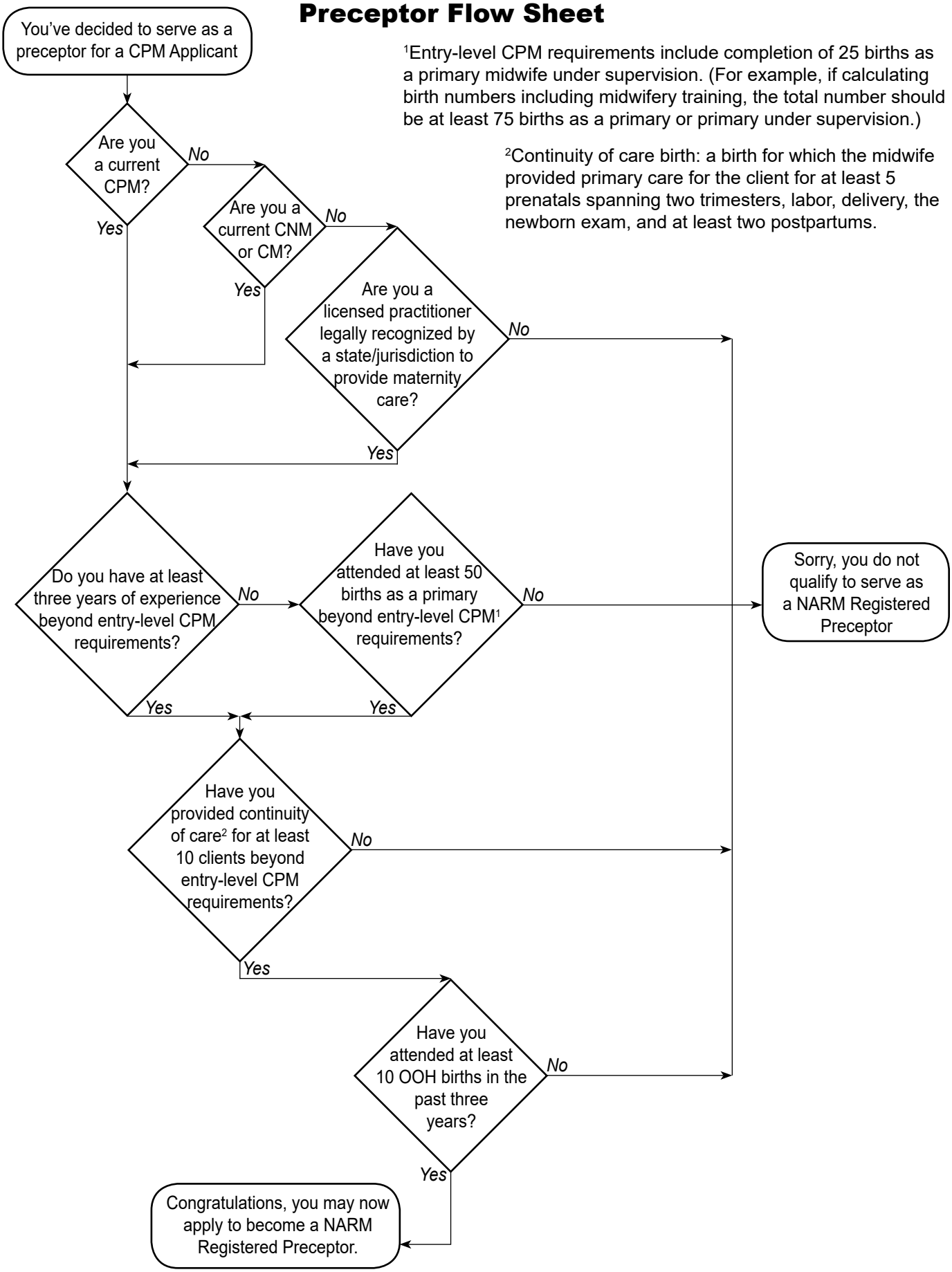
*Entry-level CPM requirements include completion of 25 births as a primary midwife under supervision. (For example, if calculating birth numbers including midwifery training, the total number should be at least 75 births as a primary or primary under supervision.)

What are the requirements of a NARM Registered Preceptor?

- Registered Preceptors practice the Midwives Model of Care.
- A Registered Preceptor may only sign for those experiences for which s/he was present and in the room in a supervisory role. Any Registered Preceptor who signs off on experiences s/he did not witness risks losing all Registered Preceptor privileges.
- A Registered Preceptor must only sign for those experiences for which s/he believes the apprentice has performed competently.
- Registered Preceptors must assign a unique code to each client who may be documented on an apprentice's application. All apprentices must use the same codes when documenting care. Apprentices should not develop different codes for the same client. Client codes must meet HIPAA requirements.

For more detailed information, read "Guidelines for NARM Registered Preceptors."

Preceptor Flow Sheet



[1]Entry-level CPM requirements include completion of 25 births as a primary midwife under supervision. (For example, if calculating birth numbers including midwifery training, the total number should be at least 75 births as a primary or primary under supervision.)

[2]Continuity of care birth: a birth for which the midwife provided primary care for the client for at least 5 prenatals spanning two trimesters, labor, delivery, the newborn exam, and at least two postpartums.

Becoming a NARM Registered Preceptor

Anyone who meets the requirements and completes registration with NARM may serve as a NARM Registered Preceptor. Here are a few points to take into consideration when deciding whether or not to serve as a preceptor.

Do you have the time and patience to serve as a preceptor?

Many apprentices are new to the field of birth work and well-woman care. The most successful preceptor/apprentice relationships result from a preceptor's ability to be patient and thorough.

Clinical skills must be taught, not just demonstrated, in increasing levels of responsibility. In addition to didactic training, hands-on practice is necessary for the apprentice to be able to advance her/his midwifery skills. It is vital that both preceptor and apprentice are willing to fully commit to the time required for extensive training.

Are you a willing and confident teacher?

Not all credentialed midwives feel that they have a well-rounded background of experience, even if they do meet the requirements of a NARM Registered Preceptor. Hopeful preceptors should consider what they have to offer the next generation of midwives before entering into the NARM Registered Preceptor role. In order to build confidence, a potential preceptor may benefit from advanced workshops and other training before taking on an apprentice.

Will you be willing to share care of your clients with your apprentice?

As an apprentice advances into the Primary Under Supervision phase of training, s/he must be able to act as the primary care provider, though the preceptor is responsible for care of the client. A NARM Registered Preceptor must be willing to allow the apprentice to completely perform procedures as a primary caregiver, only stepping in as necessary for the safety of the client or for training purposes.

Are you willing to share your records for the purposes of the NARM application process?

NARM reserves the right to request charts for any experiences documented on an application. If a NARM Registered Preceptor signs off on a clinical experience, s/he must be willing to allow the apprentice access to the charts for that client. CPM applicants are required to submit copies of a minimum of two client charts as a part of the application. It is the NARM Registered Preceptor's responsibility to confirm that copies of any charts submitted to NARM meet HIPAA requirements.

Will you be accessible to your apprentice after the CPM application is submitted to NARM?

Upon review of the CPM application, an apprentice may be required to submit corrections, additional documentation, or additional verification. NARM Registered Preceptors are often called upon to assist in verification or providing additional documentation, even if the apprentice is no longer training under that preceptor.

Guidelines for NARM Registered Preceptors

All preceptors are valued for their contributions to the field of midwifery and the continuing practice of the Midwives Model of Care. The preceptor/apprenticeship process relies on the preceptor to oversee and objectively evaluate the apprentice's training.

The training provided by a preceptor may vary widely based on the apprentice's needs. Some preceptor/apprentice relationships develop into long-term working relationships; others may be very brief. Whatever the individual experience may be, NARM has outlined the basic expectations of preceptors.

Preceptors who wish to sign off on Skills and Births for NARM CPM Applicants must register with NARM. The registration form is in this handbook and on our website at narm.org/preceptors. The form should not be filled out or submitted by anyone other than the preceptor. If a preceptor has more than one apprentice, s/he is not required to submit multiple registration forms. However, registration must be renewed every three years. The NARM Registered Preceptor is responsible for ensuring that NARM has a copy of at least one current midwifery credential (CPM, CNM, CM, LM) on file at all times. NARM Registered Preceptor status may be suspended or revoked if a preceptor does not provide proof of a current credential.

Maintain respect and open communication. In upholding the professional demeanor of midwifery, the preceptor should strive to maintain a sense of cooperation and respect for the apprentice. The preceptor should expect cooperation and respect from the apprentice as well. NARM recommends maintaining open communication at all times, with regular discussion of the expectations that each party has of the other. Any misunderstanding regarding expectations for satisfactory performance should be discussed and resolved as soon as possible. The recommended Quarterly Evaluation Form, available in this handbook (see Appendix) and at narm.org/preceptors, may serve as a useful tool for discussing expectations and goals.

NARM Registered Preceptors should have a clear understanding of the CPM educational and training requirements. For more information, refer to "CPM Educational Requirements" in this handbook, as well as the Candidate Information Booklet (CIB) and General Application Instructions, available at narm.org/entry-level-applicants.

Hold responsibility for the client. The preceptor holds the final responsibility for the safety of the client or baby. The preceptor must be physically present when the apprentice is performing clinicals and skills. Preceptors should become involved as needed for the safety of the client or in the spirit of positive education and role modeling.

Practice fair judgment. As part of the training process, the preceptor will be asked to sign for clinical skills and experiences on the apprentice's CPM application. A preceptor must only sign for those experiences for which s/he was present and s/he believes the apprentice has performed competently. **Once a preceptor signs for anything on a NARM application form, it may not be retracted.** Preceptors who sign clinicals but refuse to complete the Final Verification Form without a justifiable reason, risk having their preceptor status revoked. If there is a concern, the clinical skill should not be signed off in the first place. NARM relies on preceptors to use fair and unbiased judgment when evaluating an apprentice's abilities, regardless of personal relationships.

Assign client codes. Preceptors must assign codes to all clients who may be documented on an apprentice's application. Each birth must have a unique code assigned to it. For clients with more than one birth, a different code must be assigned for each subsequent birth. Twins must have separate client codes when documenting newborn exams. Preceptors will be asked to share copies of client charts with their apprentices for the purposes of the NARM application. It is the preceptor's responsibility to confirm that client codes and copies of any charts submitted to NARM meet HIPAA requirements.

Carefully review all documentation. Preceptors' records should indicate the presence of apprentices at each clinical and the role of the apprentice (assistant, primary under supervision) at each clinical. Both preceptor and apprentice should sign/initial the chart at the time of the clinical experience. Arrival and departure times should be noted for each person at the birth. When signing for clinical skills and experiences on the application, the preceptor should carefully review all documentation with the apprentice. NARM recommends that all skills and experiences be signed off upon completion of the clinical or skill. However, in some cases the documentation may need to be signed at a later date. In those instances, it is recommended that both apprentice and

preceptor carefully review the documentation, referring to client charts and other records to verify accuracy of client codes, clinical numbers, and all dates. Preceptors who sign for any clinical experiences or skills on an application are also required to complete the accompanying preceptor verification forms. NARM strongly urges all preceptors to keep a copy of any application form s/he signs for her records. If any experiences submitted on an application come into question, preceptors may be asked to verify those experiences. Preceptors may be contacted directly by NARM for consultation during the application process.

CPM Educational Requirements

Based on Job Analysis of current CPMs, NARM has set forth the basic educational and training requirements for becoming a CPM. While these are requirements that must be met in order to receive the CPM credential, NARM understands that individual preceptor requirements vary. For this reason, it is important that the preceptor communicate all expectations to the apprentice.

Preceptors are expected to have a clear understanding of the educational requirements of the entry-level CPM applicant, as outlined in this section. Training should be completed in increasing degrees of responsibility.

Roles of CPM training

The three roles completed in the entry-level educational training process are Observer, Assistant Under Supervision, and Primary Under Supervision.

In the Observer role, the apprentice must witness the birth. As an Observer, the apprentice is not required to participate in hands-on training or application of skills.

As an Assistant Under Supervision, the apprentice should be taught to perform the skills of a midwife. Clinical skills should be performed as an assistant in increasing degrees of responsibility. In order to document a birth as an Assistant Under Supervision, the apprentice must perform some skills and must be present throughout labor, birth, and the immediate postpartum period. Catching the baby is a skill that should be taught and performed in the Assistant Under Supervision Phase.

As Primary Under Supervision, the apprentice should be managing the birth or other clinical while still under supervision of the preceptor. The preceptor should only become involved as necessary for safety or educational purposes. In order to document a birth as Primary Under Supervision, the apprentice must manage the labor, birth, and immediate postpartum period. If the mother or father is catching the baby, the apprentice must be responsible for all elements of the delivery. The apprentice may not count a birth as Primary Under Supervision if the preceptor catches the baby.

A twin birth counts as only one birth on the CPM application.

If the apprentice or preceptor is the also the client, that birth may not be counted on the CPM application.

General requirements for entry-level CPM training:

1. The apprenticeship should include didactic and clinical experience, and the clinical training must span at least two years. Clinical experience includes births and other clinicals attended as an observer, assistant, or primary under supervision. The average apprenticeship process lasts three to five years.
2. All documentation on a CPM application must span no longer than ten years prior to submission of the application.
3. At least 2 planned hospital births and at least 5 planned home births must be included in the total births documented in Phases 1-3. These births may be documented in any combination of any role: Observer, Assistant Under Supervision, or Primary Under Supervision.
4. All CPM applicants must have developed and utilize Practice Guidelines, an Informed Consent Form, and an Emergency Care Form. For more information, please refer to the section on the Informed Consent Process (Shared Decision Making) in the Candidate Information Booklet (CIB).
5. Only one apprentice may serve as Primary under Supervision for any clinical. Two apprentices may use the same clinical as Assistant under Supervision.

Clinical requirements for all entry-level applicants include:

1. Complete at least 10 births as an Observer.
   Births may be signed by any witness, and may be in any setting. Births as an Observer may overlap with births as an Assistant Under Supervision or Primary Under Supervision (Phase 3 only).
2. Complete at least 20 births as an Assistant Under Supervision of a preceptor.
   No more than 4 of the 20 births may be transports. At least 18 births must be completed as an Assistant Under Supervision before completing births as a Primary Under Supervision.
3. Complete at least 25 prenatal exams, including 3 initial prenatals, as an Assistant Under Supervision of a preceptor.
   All 25 prenatal exams must be completed as an Assistant Under Supervision before completing prenatals as a Primary Under Supervision.
4. Complete at least 20 newborn exams as an Assistant Under Supervision of a preceptor.
   All 20 newborn exams must be completed as an Assistant Under Supervision before completing newborn exams as a Primary Under Supervision.
5. Complete at least 10 postpartum exams as an Assistant Under Supervision of a preceptor. All 10 postpartum exams must be completed as an Assistant Under Supervision before completing postpartums as a Primary Under Supervision.
6. Complete at least 20 births as Primary Under Supervision of a preceptor.
   At least 5 of the 20 births must be Continuity of Care (COC) births. In addition to the 5 COC births, at least 10 births must include a minimum of 1 prenatal visit. No more than 2 of the 20 births may be transports. At least 10 of the 20 births must be out-of-hospital births. At least 10 of the 20 births must have occurred within the last three years.
7. Complete at least 75 prenatal exams, including 20 initial prenatals, as Primary Under Supervision of a preceptor.
8. Complete at least 20 newborn exams as Primary Under Supervision of a preceptor.
9. Complete at least 40 postpartum exams as Primary Under Supervision of a preceptor.
10. Complete the Comprehensive Skills, Knowledge, and Abilities Essential for Competent Midwifery Practice.
    Both competent knowledge and practical skill must be competently demonstrated for each skill to be completed.
11. Complete an additional 5 births as Primary Under Supervision of a preceptor.
    No more than 1 of the 5 births may be a transport. These births may be submitted before or after taking the written exam, but must be completed within six months after successfully completing the written exam.

Additional requirements for successful completion of the CPM certification process include:

1. Successful completion of the Second Verification of Skills.
2. Successful completion of a course, workshop, or module on cultural awareness.
3. Current certification in Adult CPR and Neonatal Resuscitation (NNR).
   NARM only accepts certifications from courses which include a hands-on skills component. Online-only courses are not accepted. Approved CPR courses include the American Heart Association and the Red Cross. Neonatal resuscitation courses must be approved by the American Academy of Pediatrics, the Canadian Paediatric Society, or pre-approved by NARM. Certifications must be current at the time the CPM is issued. NARM strongly encourages CPR be a Health Care Provider course. Courses must be approved for use in the U.S. or Canada.
4. Successful completion of the NARM Written Examination.

For more details regarding entry-level education and application requirements, refer to the Candidate Information Booklet (CIB), the General Application Instructions, and the entry-level application forms, all available for download from our website at narm.org/entry-level-applicants.

Preceptor Registration Guidelines

Anyone who wishes to serve as a preceptor for a CPM applicant must register with NARM.

Instructions for preceptor registration with NARM:

1. Read the NARM Registered Preceptor Handbook. Those who meet the requirements and guidelines may move on to step two.
2. Complete the Preceptor Registration Form 700. Those who hold a credential other than the CPM (such as a CNM/CM or LM) must include a copy of the current credential with the registration form.
3. Complete NARM Preceptor Registration Supplemental Form 705 if you have less than three years of experience beyond the entry-level CPM requirements.
4. Submit the Preceptor Registration Form 700 and any required additional documentation to:

   NARM Applications Department
   P.O. Box 420
   Summertown, TN 38483

   Forms mailed to other NARM offices will be returned.

Original registration forms must be submitted to NARM by USPS mail. However, additional required materials may be submitted by email (applications@narm.org) or fax (888-842-4784). When submitting any documentation to NARM, the registrant must keep a copy for her/his records.

Preceptor registration dates will now align with the preceptor's active credential date. CPMs should submit the preceptor registration renewal form along with their regular CPM renewal. Non-CPMs should submit a copy of their updated license/credential along with the Preceptor Registration renewal application to the NARM Applications Department to remain a Registered Preceptor.

A verification letter will be sent by email or standard mail once the registration packet has been received, processed, and approved. The verification letter will include the preceptor's required renewal date, which will align with the preceptor's license/credential expiration date.

Receive a NARM Preceptor Registration Certificate

If your application is accepted, you may choose to buy a NARM Preceptor Registration Certificate suitable for framing for $20. Having this physical certificate is not a requirement in order to serve as a NARM Registered Preceptor.

NARM Preceptor Registration Form 700, page 1 of 3

This form must be filled out completely only *by the applying preceptor and then submitted by that preceptor.*

First Name: _____ Last Name: _____ Middle Initial:_____

Any other names previously submitted to NARM:_____

Residence Address:_____ City: _____

State/Province: _____ Postal Code: _____ Country: _____

Mailing Address*:_____ City: _____

State/Province: _____ Postal Code: _____ Country: _____

*The address where you can most easily be reached.

Primary phone #:_____ Secondary phone #: _____

Fax #:_____ Email address: _____

Last 4 digits of Social Security #:_____ Date of Birth: _____ CPM#:_____

Complete information for the credential(s) you hold. Credentials must be current and active. Fill in all that apply:

Credential	License/Credential Number	Original Issue Date	Expiration Date	State/Jurisdiction (if applicable)
CPM				
CNM[1]				
CM[1]				
LM[1]				
Other[2]				

[1]Submit a copy of your current non-CPM credential(s) with this form.

[2]Must be a licensed practitioner legally recognized by your state to provide maternity care

If there have been any lapses in your credential(s), please list the dates: _____

_____

What year did you begin practicing as a primary midwife after training? _____

How many total births have you attended (including training)?* _____

How many births did you attend as a primary/primary under supervision midwife during training?*_____

How many births have you attended as a primary midwife after training?*_____

How many Continuity of Care births have you attended as a primary midwife?* _____

NARM defines Continuity of Care births as a minimum of five prenatals spanning at least two trimesters, the birth, the newborn exam, and at least two postpartums.

How many Out-of-Hospital births have you attended in the last three years?* _____

Do you work with a group practice or birth center, or do you work with a co-practitioner? ❑ Yes ❑ No

If yes, please state the name(s): _____

*Approximately

NARM Preceptor Registration Form 700, page 2 of 3

First Name: _____ Last Name: _____

May NARM release your name/contact information to prospective apprentices looking for a preceptor?
❑ Yes ❑ No

How did you receive your midwifery training? Please complete all that apply:

❑ Self-trained, please provide a brief explanation: _____

_____

_____

❑ Apprenticeship towards NARM credential

❑ Apprenticeship towards a credential offered by a state/provincial agency
Name/location of agency: _____

❑ Obtained a degree towards CNM/CM certification

❑ Obtained a vocational/technical certificate
Name of program/certificate: _____

❑ Attended a MEAC-accredited school
Name of school: _____
Did you graduate? ❑ Yes ❑ No

❑ Attended a midwifery school not accredited by MEAC
Name of school: _____
Did you graduate? ❑ Yes ❑ No

❑ Attended a state-approved midwifery program
Name of program: _____
Did you complete the program? ❑ Yes ❑ No

❑ Obtained a credential outside the U.S.
Name/location of credential: _____

❑ Attended a training program outside the U.S.
Name of program: _____

❑ Other, please explain: _____

_____

NARM Preceptor Registration Form 700, page 3 of 3

First Name: _____ Last Name: _____

Affirmation of Honest Intent of Representation

I, _____, in registering for North American Registry of Midwives (NARM) preceptor status, do hereby acknowledge that honesty in relationship to the apprentices I mentor is of utmost importance. I affirm that I, to the best of my ability and professional integrity, will always represent my practice, knowledge, skills, experience and expertise honestly and fairly. *Initial here:* _____

I understand that I will be held liable for the verification of education and training of any CPM applicants who apprentice under my supervision. *Initial here:* _____

I affirm that I have read the NARM Registered Preceptor Handbook and agree to all terms therein.
Initial here: _____

I affirm I have read the Candidate Information Booklet (CIB) and NARM application instructions.
Initial here: _____

I affirm that, as a NARM Registered Preceptor, I will only sign for procedures performed under my direct supervision, for which I was present and in the room. Before signing any NARM application forms, I will thoroughly review the procedures documented on those forms. *Initial here:* _____

I declare and affirm that the statements made on this registration form, including accompanying statements and documents, are true, complete and correct. I understand that any false or misleading information in connection with my registration may be cause for denial or loss of preceptor status.
Initial here: _____

_____
Print Name

_____ _____
Signature Date

_____
Witness Name Affirming Preceptor's Signature

_____ _____
Witness Signature Date

Glossary

The terms defined herein are specific to the CPM process.

Accountability: The check and balance system built into the certification process. Accountability includes continuing education, informed consent, peer review, complaint review, and the grievance mechanism.

ACNM: American College of Nurse-Midwives; the professional association that represents Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) in the United States.

AMCB: American Midwifery Certification Board.

Assistant Under Supervision: An apprentice midwife who is being taught to perform the skills of a midwife through hands-on clinical experience in gradually increasing degrees of responsibility.

Audit: A methodical examination and review of application materials, including any additional requested materials, such as practice documents and charts. Audits may be conducted randomly or for multiple discrepancies on any application type, including recertification applications.

Birth: Labor, delivery, and immediate postpartum period.

CIB: Candidate Information Booklet; A booklet published by NARM which outlines educational and application requirements for becoming a Certified Professional Midwife (CPM).

CPR: Cardiopulmonary Resuscitation.

CNM: Certified Nurse Midwife; An advanced practice registered nurse who has specialized education and training in both the disciplines of nursing and midwifery and is certified by the AMCB.

CM: Certified Midwife; A direct entry midwife who is certified by the AMCB.

Certified Professional Midwife (CPM): A professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and adheres to the Midwives Model of Care.

CEU: Continuing Education Unit; continuing education credits which are usually represented as credit hours but sometimes as units. For NARM recertification 1 contact hour equals 1 CEU.

Charts: A record of information about a client. Complete charts include the prenatal care record, labor and delivery records, newborn exam record, and postpartum record.

Client: A person who elects to use midwifery services provided by a professional midwife, which may include care provided by apprentice midwives.

Client Code: Each client must have a unique code. If there is more than one birth, including twins, with any given client, there must be a different code assigned for each subsequent birth. If a preceptor has more than one apprentice (applicant), each chart must have a code that all apprentices will use. Apprentices should not develop different codes for the same client.

Clinical: Any direct observation or evaluation of a client, e.g. – a birth, prenatal, postpartum, or newborn exam.

Clinical Experience: Any experience involving direct observation or evaluation of a client and signed for by a witness or preceptor.

Complaint Review: A group review by CPMs, conducted locally, regarding a formal complaint filed against a CPM within 18 months of the conclusion of care (or within the time allowed by NARM policy). Complaint Review includes participation of the client whose course of care initiated the complaint, and may result in non-binding educational recommendations for the midwife or initiation of the NARM Grievance Mechanism.

Confidentiality: The protection of individually identifiable information, specifically client information.

Continuing Education: Keeping up with new developments in the field of midwifery, upgrading skills, acquiring new information, and reviewing skills and knowledge.

Continuity of Care (COC): Care provided throughout prenatal, intrapartum and postpartum periods. For the purposes of the NARM application, primary under supervision care must be provided for a minimum of five prenatals spanning at least two trimesters, the birth (including the placenta), the newborn exam, and at least two postpartums for five clients. Transports are not accepted for full Continuity of Care births. An additional ten primary under supervision births must include at least one primary under supervision prenatal.

Core Competencies: The Midwives Alliance of North America Core Competencies; a document of guidelines which establish the essential knowledge, clinical skills and critical thinking necessary for entry-level midwifery practice, providing the basis for the CPM credential.

Currency: Documentation of additional births and/or clinicals, which may be required for applications that have been in process for an extended period of time. Minimum required clinical experiences must span no longer than ten years, with at least ten out of hospital births within the last three years.

Education and Counseling: Information and discussion of components of the CPM Informed Consent Process and Shared Decision Making, provided in verbal and written language understandable to the client.

Eligibility: Process by which one may seek and obtain certification based upon personal, program, organization, state or international qualifications.

Emergency Care Form: A form individualized for each client, which should include the client's name, address, phone number, hospital chosen for transport (with telephone number), name and contact information of anyone who may be involved in the care of the client (such as client doctors or the backup physician for the midwife), and any person that the client lists as an emergency contact.

Expired CPM: One who has previously been issued the CPM credential but, within 90 days after her/his expiration date, has not provided documentation of maintaining the requirements of recertification.

Expired Application: An application which has been submitted to the NARM Applications Department and has been in process or incomplete for longer than the allowed time frame.

Fetal/Neonatal Death: A death from 20 weeks intra-uterine gestational age to 28 days old.

Freestanding Birth Center: A facility, institution, or place not normally used as a residence and not associated with or managed by a hospital, in which births are planned to occur in a home-like setting. Freestanding birth center births are considered out-of-hospital births.

Grievance Mechanism: The process used by the NARM Accountability Committee to handle formal complaints about a midwife, which is put into effect once a second complaint against a CPM or applicant is filed. The outcome is binding, and failing to meet the stated requirements results in the revocation of a CPM's credential, conditional suspension or denial of an application.

HIPAA Requirements: The requirements as laid out in the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), which are intended to protect all "individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral," also known as protected health information. Protected health information may not be used or disclosed unless the individual who is the subject of the information authorizes in writing.

Hospital Birth Center: A birth facility, institution, or place associated with or managed by a hospital, which is equivalent to a hospital setting for a birth.

ICA: International Credentialing Associates; an independent, non-governmental professional organization which provides educational credential evaluation reports to other organizations for individuals who have completed all, or part, of their education outside the United States.

Inactive CPM: Voluntary suspension of CPM credential on an annual basis not to exceed six years; during which time the use of the CPM credential and preceptor/evaluator status is prohibited.

Informed Consent Form: A midwife's documentation of the process leading to the decision made by a client that is outside the Midwife's Plan of Care, which must include evidence, such as the client's signature, that the client was fully informed of the potential risks and benefits of proceeding with the new care plan.

Informed Consent Process: Ongoing verbal and written education about risks, benefits and alternatives to the Midwife's Plan of Care. The midwife utilizes individualized counseling based on her practice guidelines and skill level, the client's medical history, and written documentation of a care plan that includes signatures of the client and midwife when appropriate. The Informed Consent Process necessitates revisiting areas of consent and non-consent over time and as changes occur. Also refer to Shared Decision Making.

Informed Disclosure: A form written in language understandable to the client which includes a place for the client to attest that she understands the content by signing her full name. The form must include a description of the midwife's training and experience (including credentials), philosophy of practice, list of services provided, transfer/consultation protocols, transport plan, the NARM Accountability Process, and HIPAA Privacy and Security Disclosures.

Initial Prenatal Exam: Intake interview, history (medical, gynecological, family) and physical examination. Information may be gathered over one or more early prenatals and should include both an oral/written history and a general overview of normal physical condition.

Licensed Midwife: A midwife who is legally recognized and regulated by her/his state.

MANA: Midwives Alliance of North America.

MEAC: Midwifery Education Accreditation Council.

Mediation: Process utilizing a third agreed upon party to bring about agreement or reconciliation among disputing parties.

Mentor: See Preceptor.

Midwife: One who attends a woman in childbirth as the primary care provider.

Midwife's Plan of Care: A care plan provided by the midwife to her client that is informed by her training, competency, practice guidelines, regional community standards of both medical and midwifery maternity care providers, and legal requirements. The Plan of Care includes both written and verbal communication and is revisited throughout the course of care as changes occur and at the time an exam or procedure is provided. A client may refuse a procedure at any time.

Midwives Model of Care: A midwifery model of care based on the fact that pregnancy and birth are normal life events. The Midwives Model of Care includes: a) monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle; b) providing the mother with individualized education, counseling and prenatal care, continuous hands-on assistance during labor and delivery and postpartum support; c) minimizing technological interventions; and d) identifying and referring women who require obstetrical attention. The application of this model has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

NARM: North American Registry of Midwives.

NARM Registered Preceptor: A midwife who meets requirements for supervising CPM candidates and has current, approved registration through NARM. The Registered Preceptor must be credentialed as a Certified Professional Midwife (CPM), Certified Nurse Midwife (CNM), Certified Midwife (CM); or s/he must be a licensed practitioner legally recognized by a state/jurisdiction to provide maternity care. A preceptor must have an additional three years of experience after credentialing or fifty primary births beyond entry-level CPM requirements. Additionally, s/he must also have ten continuity of care births beyond entry-level CPM requirements. A preceptor must have attended a minimum of ten out-of-hospital births in the last three years.

Newborn Exam: A complete and thorough examination of the infant conducted within 12 hours of the birth.

NNR: Neonatal Resuscitation.

Observer: One who is physically present and observes a labor and birth.

OOC: Out of Country; specifically, midwifery training conducted outside the U.S. or Canada.

Out-of-hospital (OOH) Birth: A planned birth in a home, freestanding birth center, or other location not connected to a hospital.

PEP-EL: Portfolio Evaluation Process – Entry Level; the application route through which midwifery apprenticeship with one or more preceptors is thoroughly documented for review for the purpose of qualifying for the CPM credential.

PEP-EM: Portfolio Evaluation Process – Experienced Midwife; the application route through which a midwife's experience (a minimum of five years of experience beyond training) is thoroughly documented for review for the purpose of qualifying for the CPM credential.

PEP-IEM: Portfolio Evaluation Process – Internationally Educated Midwife; the application route through which the experiences and training of a midwife licensed or registered outside the U.S. is thoroughly documented for review for the purpose of qualifying for the CPM. Documentation includes an initial report requested by the applicant and compiled by ICA.

Phase 1: The first of four phases of the PEP-EL application, requiring documentation of births attended as an Observer. Phase 1 serves as a beginning apprentice's introduction to the preceptor's practice.

Phase 2: The second of four phases of the PEP-EL application, requiring documentation of midwifery clinical experience as an Assistant Under Supervision. Phase 2 provides the apprentice with appropriate instruction and training in preparation for providing primary midwifery care under the direct supervision of a preceptor during Phase 3.

Phase 3: The third of four phases of the PEP-EL application, requiring documentation of midwifery clinical experience as a Primary Under Supervision, verification of skills, CPR certifications, verification of utilization of practice documents, and references.

Phase 4: The fourth of four phases of the PEP-EL application, requiring documentation of additional births as a Primary Under Supervision.

Philosophy of Birth: A written or verbal explanation that a midwife provides as part of Informed Disclosure for Midwifery Care in which the midwife explains her/his beliefs and opinions about the process of childbirth and the role of the midwife as care provider.

Plan of Care: See Midwife's Plan of Care.

Planned Home Birth: A birth that, according to the antepartum plans set forth by the client, takes place in a home or similar setting.

Planned Hospital Birth: A birth that, according to the antepartum plans set forth by the client, takes place in a hospital or hospital birth center. A planned hospital birth may be a transfer of care from an out-of-hospital practice.

Postpartum Exam: A physical, nutritional and socio-psychological review of the mother and baby after 24 hours and up to six weeks following the birth, and does not include the immediate postpartum exam.

Practice Guidelines: A specific description of protocols that reflect the care given by a midwife, including the initial visit, prenatal, labor/delivery, immediate postpartum, newborn exam and postpartum care. Practice Guidelines should include an explanation of both routine care and protocols for transports and/or transfers of care.

Preceptor: See NARM Registered Preceptor.

Prenatal Exam: A complete and thorough routine examination, counseling, and education of the pregnant woman prior to birth.

Primary: A midwife who has full responsibility for provision of all aspects of midwifery care (prenatal, intrapartum, newborn and postpartum) without the need for supervisory personnel.

Primary Under Supervision: An apprentice midwife who provides all aspects of care as if s/he were in practice, although a supervising midwife has primary responsibility and is present in the room during all care provided.

Protocols: See Practice Guidelines.

Recertification: The process through which a CPM renews credentialing every three years by documenting CEUs, peer review, cultural awareness (if not previously documented), and current CPR certifications.

Recertification After Expiration: The process through which an expired CPM may reapply for the CPM credential by documenting birth experience, CEUs, peer review, cultural awareness, and current CPR certifications. The expired CPM will be required to retake the written exam unless s/he holds another current credential (such as a state license) recognized by NARM.

Registered Midwife: See Licensed Midwife.

Second Verification of Skills: The secondary evaluation of a PEP applicant's skills verified either in a clinical setting or demonstrated on live volunteer models.

Shared Decision Making: The collaborative process that engages the midwife and client in decision making with information about treatment options, and facilitates the incorporation of client preferences and values into the plan of care. Also refer to Informed Consent Process.

Standards of Practice: See Practice Guidelines.

State Licensed: See Licensed Midwife.

Supervisor: See NARM Registered Preceptor.

Transport: Transfer of care during labor to another primary care giver prior to the birth of the baby. In the case of transfer, the apprentice must remain with the client through the birth (if possible) and continue to be present through the immediate postpartum period. The supervising preceptor must be present until transfer of care has occurred.

Witness: Anyone other than the applicant present at a birth.

Written Exam: North American Registry of Midwives Written Exam.