



MEDICAL BOARD OF CALIFORNIA Midwife Reviewer Program



ORIGINAL APPLICATION

LAST NAME:	FIRST NAME:	MIDDLE NAME:	SUFFIX
MAILING ADDRESS:		CITY:	STATE: ZIP:
ALTERNATE MAILING ADDRESS (NOT A P.O. BOX) FOR EXPERT PACKAGES:		CITY:	STATE: ZIP:
TELEPHONE NUMBER:	CELL NUMBER:	WORK NUMBER:	
CALIFORNIA MIDWIFE LICENSE NUMBER:		EMAIL ADDRESS:	

1. List all education and training you have received. Please include dates and locations.
2. Describe your midwife experience. Please list total number of deliveries you have attended during your length of practice. Also, list date of most recent delivery.
3. List each county location where you currently practice.
4. List any current faculty appointment(s); date and type of appointment(s), your title; and the name and location of each Institution.
5. Describe any prior peer review experience.



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APPLICATION SURVEY

How did you learn about the Medical Board's Expert Reviewer Program?

- Medical Board of California Newsletter

- Medical Board of California Website

- CMA Publication

- Specialty Board Publication (name) _____

- Medical Society Publication (name) _____

- Word of Mouth (name) _____

- Recruitment via an event or marketing ad (location) _____

- Email Link (indicate) _____

- Other _____