



MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2393
Fax: (916) 263-2435
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

Transfer of Planned Out-of-Hospital Delivery to Hospital Reporting Form

Business and Professions Code section 2510 requires a hospital to report each transfer by a licensed midwife of a planned out-of-hospital birth to the Medical Board of California and the California Maternal Quality Care Collaborative. The **hospital must complete** this form and **submit as follows**:

- **Send** the full completed form to: Medical Board of California, Attn: Licensed Midwifery Program, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815 **or fax** to (916) 263-2435; **and**
- **Send a copy of page one only** to: California Maternal Quality Care Collaborative, Medical School Office Building, 1265 Welch Road, MS 5415, Stanford, CA 94305 **or fax** to (650) 721-5751.

Hospital and Admission Information	
Hospital Name:	
Hospital Address:	
Date of Admission:	Time of Admission:
Name of Healthcare Provider Assuming Care: (first, middle, last)	License Type and Number:
Person(s) admitted: <input type="checkbox"/> Pregnant Mother <input type="checkbox"/> Delivered Mother <input type="checkbox"/> Newborn(s)	
Patient *Pre-Registered at this hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient was Pre-Registered at another hospital	
Name of other hospital: _____	
*Pre-Registered means the mother had been previously registered at the hospital for possible delivery.	
Transport/Transfer Information	
Reason for transfer:	
Name of licensed midwife treating patient prior to transfer: (first, middle, last)	License Number:
Licensed midwife called in to report transfer:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Licensed midwife arrived with patient:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Licensed midwife provided hospital with medical records, including prenatal records:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Licensed midwife spoke with and provided report to physician regarding care up to the point of transfer:	<input type="checkbox"/> Yes (provide name and license below) <input type="checkbox"/> No (provide reason below)
If yes, name of physician information was provided to by the licensed midwife: (first, middle, last)	License Number:
If no, reason no report was given: <input type="checkbox"/> Physician Unavailable <input type="checkbox"/> Licensed Midwife Unavailable <input type="checkbox"/> Other: _____	

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Patient Name: (First, Middle, Last)

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**DO NOT SUBMIT THIS PAGE TO THE
CALIFORNIA MATERNAL QUALITY CARE COLLABORATIVE**
