



## APPLICATION TO ESTABLISH AN ALTERNATE PRACTICE ARRANGEMENT

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

APA Practice Name: _____ APA Practice Address: _____ _____ Anticipated APA Start Date: _____ APA Practice Website: _____ Midwife/Midwives Applying and Registration Numbers: _____ _____ _____ _____ _____
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**Please submit a proposal with this application including the following required information in the sections set out below.**

### Demographic Information

1. The geographic catchment area to be served by your APA.
2. Approximately how many clients/families your APA will serve annually.
3. Available population, provider and demand data relevant to the catchment area.

### Standards of Practice Deviations

4. Each proposed deviation from the *Standards of Practice*, with rationale.
5. A detailed explanation of how care will be delivered in your proposed alternate practice arrangement and how it will (as applicable):
  - a) contribute to a high quality of perinatal care in context of proposed exceptions to *Standards of Practice*;
  - b) address a perinatal care need;
  - c) ensure a high level of client satisfaction;
  - d) improve access to perinatal care;
  - e) contribute to health promotion and disease prevention;

- f) maintain or increase clinical learning opportunities for midwifery and other students; and
- g) include a sustainable funding model.

**Communication and Transparency**

- 6. Your strategy for communicating the details of care and standards deviation by your APA to clients and the public (e.g. on your website, client information documents, etc.). Please include examples of and links to information provided publicly.

**Quality Assurance and Evaluation**

- 7. Your plan for self-evaluation and quality assurance for your proposed APA.
- 8. Any new competencies, skills and/or knowledge that you believe you will gain while working in an APA.
- 9. Any competencies, skills and/or knowledge that may require support to regain if and when you return to the Standard Model (e.g. home birth services, postpartum care, etc.).

**Please list and enclose any additional document(s) you are providing in support of your application (e.g. client documents/handouts, letters of support, etc.):**

**Declaration**

I/We agree to inform my/our clients that the midwifery care they are receiving is within the context of an Alternate Practice Arrangement.

I/We have reviewed CMBC's *Policy on Alternate Practice Arrangements, Midwives Regulations, and Bylaws for the College of Midwives of BC* and agree to provide care consistent with the standards outlined in these documents.

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## PAYMENT

**Instructions to Registrant(s)**

Please send completed form with the required \$100.00 fee to:

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA  
#603 - 601 West Broadway, Vancouver, BC V5Z 4C2

**OR**

If you prefer to pay by credit card, please indicate who CMBC should contact to make this payment:

\_\_\_\_\_

Please indicate to whom CMBC should issue a receipt:

\_\_\_\_\_