HEALTH CARE AUTHORITY

DEPARTMENT

AFFIDAVIT AND CERTIFICATION OF LIABILITITY INSURANCE COVERAGE

AFFADAVIT OF: _____
(Name of Midwife)

STATE OF NEW MEXICO

COUNTY OF_____

I, _____ being duly sworn, depose and state as follows:
(Name of Midwife)

1. I am licensed as either a Licensed Certified Nurse-Midwife (CNM) or a Licensed Direct-Entry Midwife (DEM) to perform midwifery services in the State of New Mexico.

2. Select one:

____ I have not had any judgments against me in the past five (5) years for any midwife or related service I have performed or been responsible for; or

____ I have had a judgment or judgments against me in the past five (5) years for a midwife or related service I have performed or been responsible for. (Attach a brief statement of situation; date; state, city, county and professional association or court which handled the matter; any docket number or case identification; and the adjudication or other result.)

3. Select one:

____ I have not had any malpractice claims or other negligence claims brought against me in the past year (from _____ to _____) for any midwife or related service I have performed or been responsible for; or

____ I have had malpractice claims or other negligence claims brought against me in the past year (from _____ to _____) for a midwife or related service I have performed or been responsible for. (Attach a brief statement of situation; date; state, city, county and professional association or court which handled the matter; any docket number or identification; and the adjudication or other result.

4. Select one:

____ I am presently covered by malpractice insurance and/or professional liability insurance in the minimum amount of $600,000 aggregate coverage and $200,000 coverage per wrongful act or occurrence, but I have been unable to obtain such coverage for out-of-hospital birth services, or;

____ In the past twelve (12) months, I have attempted to obtain malpractice insurance and/or professional liability insurance in the minimum amount of $600,000 aggregate coverage and $200,000 coverage per wrongful act or occurrence from at least three (3) different insurance carriers to cover malpractice claims or other negligence claims for my professional practice in midwifery in New Mexico; or

____ I am submitting a blanket statement, which will be revisited and provided every twelve (12) months, from three insurers obtained by the New Mexico Midwives Association or the American College of Nurse Midwives V/1 (copy or copies of such information is attached to this Affidavit); or

____ I have been given premium quotes for insurance coverage in the amounts stated above that exceed twenty percent (20%) of my annual gross income from out-of-hospital birthing services performed as a licensed or certified midwife. Attached to this Affidavit is proof from the insurance carriers as to the quoted premiums or denial of coverage, with proof of my annual income from services performed as a licensed or certified nurse midwife.

FURTHER AFFIANT SAYETH NOT.

Affiant: _____

Date: _____

SUBSCRIBED AND SWORN to before me by:

Midwife: _____

Date: _____

Notary: _____

My commission expires: _____
Date

Approved: _____
MAD PPSB Bureau Chief Date