



FLORIDA | Council of Licensed Midwifery
October 23, 2017

DRAFT MEETING MINUTES
Council of Licensed Midwifery
October 23, 2017
10:00 am

Call in Number: 1(888)670-3525
Participant Passcode: 7133577864

The meeting was called to order at 10:00 am.

Those present for all or part of the meeting included the following:

MEMBERS PRESENT:

Melissa Conord-Morrow, LM, Chair
Charlie Young, LM
Dana Barnes, MD
Robert Pearson-Martinez, MD
David S. Stewart, MD
Kathy Bradley, Consumer Member

MEMBERS ABSENT:

Tania Mondesir, RN, LM
Susan Robyn Mattox, LM, Vice-Chair
Corrine Audette, CNM, ARNP

STAFF PRESENT:

Kama Monroe, J.D. Executive Director
Carol Taylor, Program Administrator
Christa Peace, RSIII
Gerry Nielsen, Regulatory Supervisor

DEPARTMENT COUNSEL:

Linda McMullen, Assistant General Counsel
DOH Office of the General Counsel

COURT REPORTER:

For the Record
850-222-5491

*Please note the minutes reflect the actual order agenda items were discussed and may differ from the agenda outline.
Minutes from this meeting can be found online: <http://www.floridahealth.gov/licensing-and-regulation/midwifery/meetings/index.html>*

Review and Approval of Minutes

1. September 25, 2017, Conference Call Meeting Minutes

September 25, 2017, minutes were presented for approval. Dr. Barnes noted the minutes were accurate but suggested for future reference to include more detail. She noted she could not remember the detail of the suggestions made at the September meeting. Ms. Monroe reviewed the two main suggestions from the last minute for the benefit of the council.

Motion by Melissa Conord-Morrow, seconded by Kathy Bradley, to accept the minutes as presented.

Motion carried.

General Business:

2. 2017 Annual Report as of October 13, 2017

Council chair noted that this was more of a test year than a reporting year due to the number of discrepancies in the report. She noted that the number of deliveries in a hospital does not appear accurate. She personally does not know that many licensed midwives who can deliver in a hospital. There is a need to identify who that is because it appears the number of deliveries that were transferred into a hospital were counted as hospital deliveries. Also the number of unplanned breech and unplanned twins delivered were counted in both transferred out and the unplanned columns. She opined the question needs to be changed to state the number you actually delivered. The chair also questioned where the department was with the nineteen licensees who did not report. Ms. Monroe provided an update. Council chair further noted that there were two individuals who appeared to do nothing but pre-natal care. She noted that that would skew the numbers as far as outcomes. Council chair further noted that the raw data reflected that those requiring sutures were 24.6%, post-partum transfers were 3%, intra-partum transfers were 12%, newborn transfers were 1%, and stillborns and deaths within seven days were less than .003, which indicates midwives are doing a good job. Another area of interest is the number of students under a midwife during a reporting period. The council chair noted one person noted twenty students during the reporting period, which is large. Ms. Monroe suggested that when the report is submitted, the council could include any concerns in a written paragraph with the report, i.e. the council has the following concerns. Department counsel noted they should be referred as comments not concerns. Department counsel further noted that whatever the comments might be it could be concluded that the council will continue to work to achieve a reporting vehicle that addresses these comments. Dr. Stewart noted that it should be comments, not concerns, because concerns prejudices the data. The data is raw and open to interpretation. The council chair again noted her concern that this information is only for test year purposes for getting everything evaluated and structured properly. Department counsel noted that it might be taken into consideration that some of the reporters this year may not have used the form with the expanded instructions. Ms. Young noted discrepancies in what was reported and what was in Excel sheet. She further noted that the form is not getting the information that is wanted. Discussions with licensees who reported, noted that it wasn't clear what was being requested. She noted some items that were reported that did not make sense. Department staff noted they would re-review the data entry to ensure accuracy; however, while on the call staff confirmed that the information reported by council chair was indeed accurate on the Excel spreadsheet. Ms. Young opined that the data was null and void. Department counsel noted that "we got what we asked for, it may not be what you want, but we got what we asked for in terms of the form," the form might need to be revised if you are not happy with the results. Ms. Monroe noted the council might wish to create a subgroup in order to work on making form suggestions so that we can have a new version hopefully promulgated in time for next year. Dr. Barnes noted that the instructions were pretty solid and it might be beneficial to have the instructions incorporated directly on the form as a way to provide more inclination for licensees to read them. Ms. Young noted that not everyone received the instructions as they were not yet mandated, which was part of the problem. Department counsel corrected Ms. Young and informed her that the instructions were e-mailed to everybody even before they were final, so they were e-mailed to every licensee, they were available and they were posted, whether or not the licensees availed themselves to those instructions we do not know. Ms. Young brought up a letter to go along with the report. Department council noted that it would be best to do as Ms. Monroe suggested at the beginning of the meeting by including comments with the report. That way it would never be separated from the report. Council chair asked if her previous comments would be transcribed from the meeting or should she send them. Ms. Monroe noted she should do her

bullet points verbally. That way if anyone else on the council had comments they wanted to add they could do so. Bullet points include:

- Need to do something about line items one and two, should be instructions, so hopefully will be corrected next year
- As an outlier, would like to see if they have more than five students, that it be addressed to see if they are in a school setting where they are coming in contact with that many students
- The number delivered at the hospital, it must specify that those are delivered by the midwife
- The number of unexplained breeches and twins, it needs to say that those were delivered by the midwife and reported on the birth certificate and not included as a transfer
- The two outliers, how will the council address those who are in large clinic practices not delivering so the numbers are not effected
- The new licensees are all zeroes, did they have to report, question to be answered

Ms. Young again mentioned the raw data being incorrect. Dr. Stewart noted he did not want to say the data was incorrect as he had no verification that the information was incorrect. Ms. Young asked council chair to verify her numbers were incorrect. Mr. Nielsen informed the council that Ms. Conord-Morrow's information was correct on the spreadsheet and assured the council that the numbers would be reviewed and accuracy verified prior to reporting. The Department will not file an incorrect report.

Ms. Monroe noted the statement that this is a new form and a relatively new requirement was not included in the bulleted comments and asked if that was something the council wanted to include with the comments. Council chair asked that the comment be included.

Motion by Melissa Conord-Morrow, seconded by David Stewart, to accept the 2017 annual report from October 13, 2017, with the included comments. Motion carried.

Rule Discussion

3. Rule 64B24-7.014 Midwifery Records and Reports
DH-MQA 5011 Promulgated Form and Reports

Ms. Monroe noted that the information under this tab was included for informational purposes only.

Reports:

4. Executive Director's Report

Ms. Monroe made the council aware of Senate Bill 510 which is the adverse incident bill that will affect midwives. Currently there is no sponsor but it is a bill.

Additionally, Ms. Monroe informed council members that there had been complaints about not receiving e-mails. Ms. Monroe reminded council members that the Department must have correct e-mails. She further instructed council members to e-mail the zzz box for midwifery with any questions. The zzz box is monitored daily. Ms. Monroe provided current staff information and also noted that current staff contact information would be e-mailed to the council.

Ms. Monroe noted that it is time for election of officers. The item will be placed on the next agenda.

5. Application Liaison –

There was no report at this time

6. Budget – Kathy Bradley

There was no report at this time

7. Community and Consumer Relations - Kathy Bradley

There was no report at this time.

8. International Relations –

There was no report at this time.

9. Laws & Rules and Other Agency Action – Susan (Robyn) Mattox

There was no report at this time

10. Unlicensed Activity – Susan (Robyn) Mattox, L.M.

There was no report at this time.

11. Healthy Weight Initiative – Melissa Conord-Morrow

There was no report at this time.

12. Counsel Report – Linda McMullen, Esq.

There was no report at this time.

Old Business

13. Annual Report Form Revisions

Ms. Monroe asked how the council wished to move forward as far as changes to the form. After receiving no comments, she inquired if the council wanted the Department to move forward with revisions and suggestions. Ms. Young asked if the council had statutory authority to change to MANA reports. Ms. McMullen noted that the statute requires the licensees to submit an annual report and then the details of the report are flushed out by the rule. That would be part of the discussion of revising the rule if that is the way the council wishes to go. There are certain subjects that must be reported but it is very broad. Basically, you would be reporting the same data just in a different format. It would require going through the rulemaking process. Ms. Conord-Morrow wanted to know how soon they could meet as a committee on making changes. Dr. Stewart requested discussion as to whether everyone wanted to change the form, noting that the current form was just put in place. Ms. Conord-Morrow noted that even if they didn't change the form of reporting, the current form needed revisions. Department council provided direction as to the requirements for a workshop. It would take the council to make changes. Dr. Stewart noted his objection to a committee to make changes. He opined that the current form had not been afforded an opportunity to work. Ms. Young informed Dr. Stewart that using MANA stats had previously been considered and that she believes that other forms have to be considered. Dr. Stewart again noted that information incorrectly reported makes the state look bad. He indicated that the licensee will still report inaccurately. Ms. Young noted that MANA stats is more comprehensive and it provides better checks and balances. Dr. Stewart requested an opportunity to review the MANA stats website before a committee is formed. Department council noted that it could not be mandated that a licensee use MANA stats. A new format would have to be created duplicating that project with whatever resources the Department has. She further noted that there is a budget and the budget for midwives is small and usually operates in the red. Ms. McMullen noted that more information should be disseminated to council members before moving forward. Ms. Young again requested a committee to look for comments to be added, look for changes, etc. Ms. Young volunteered to be on the committee. With no other volunteers, Ms. Monroe noted willingness to work with Ms. Young to come up with suggestions. Ms. McMullen noted a possibility of running into a sunshine issue if members of the public are included. Ms. Conord-Morrow subsequently indicated her desire to be included in the committee.

14. Workgroup for Rule 64B24-7.004, Florida Administrative Code- Risk Criteria Rule

Department staff reminded the council that the rule was brought up at the last meeting as a rule wherein previous discussion had ensued regarding rule development. At the September meeting it was questioned what had happened with the rule. Department staff noted at the September meeting that the previous information would be pulled and placed on this agenda; therefore, it was placed on this agenda for council consideration. Council members indicated that there had not been enough time to hash out the specific details, noting that it was an important portion of their work. The council decided to move

this item to the next agenda.

15. Materials Presented at the 09/25/17 Council Meeting (Informational Purposes Only)

The materials were placed on the agenda for informational purposes only. There were no comments.

New Business

No new business.

Ms. Conord-Morrow requested further elaboration between the difference between a board and a council and the need for a quorum. There is no legal requirement that a council have a quorum but you want a quorum because you want as many of the council to participate as possible. The question could probably be answered by reviewing the role of a council. Ms. McMullen reminded members that they can not speak of items that have been or will probably come before the council outside of a council meeting. Committee members can speak to each other regarding the subject of the committee.

Adjourn:

Next Meeting: September 25, 2018

Annual Report of Midwifery Practice

2018 (FY 2017-2018)
Florida Council of Licensed Midwifery

Section I: Overview

A. Requirements of the Licensee

The Midwifery Annual Report is derived from data provided using the *Annual Report of Midwifery Practice (DH-MQA 5011)*, a form developed for self-reporting of midwifery statistics on an annual basis. Licensed Midwives whose licenses are active are required to report by July 31st each year under Rule 64B24-7.014(6), Florida Administrative Code.

B. Development of the Midwifery Annual Report

The *Annual Report of Midwifery Practice (DH-MQA 5011)* was first required in July of 2016 for the 2015-2016 fiscal year. Since 2016, the Council of Licensed Midwifery, acting in an advisory capacity, has provided insight as to how the form might be further refined, the types of data collected, and how that data may be interpreted in the context of the profession of midwifery.

C. Reporting Rates

The Department has worked to increase communications with Licensed Midwives concerning submission of annual report data, and in FY 2017-2018, took action against licensees who failed to report, in accordance with Rule 64B24-7.014(7), Florida Administrative Code.

Reporting rates for the *Annual Report* have improved significantly over the three reporting cycles:

Reporting Period	Licensees Required to Report	Reports Received	Percentage Returns
FY 2015-2016	143	51	35.7%
FY 2016-2017	198	177	89.3%
FY 2017-2018	206	200	97.0%

D. Limitations of the Dataset

The dataset compiled from the *Annual Report of Midwifery Practice (DH-MQA 5011)* is subject to inaccuracy introduced by licensees less familiar with the reporting mechanism, by error, or by omission.

The *Annual Report of Midwifery Practice* is designed to observe general trends within the profession, and to assess where regulatory response is appropriate in relation to the observed trends. The Annual Report of Midwifery Practice is not intended to provide information about specific midwives or specific cases.

Outliers – Required Reports for Non-Practicing Midwives

A significant number of licensees who were required to report do not appear to practice in Florida. Of the licensees in ACTIVE status in the reporting period, 46 out of 200 reported “0,” “none,” or similar in each data field. This represents 23% of the licensure base which hold an active license, but do not practice in Florida. The non-practicing results received are considered outliers for all analyses related to practice.

Section II. Midwifery Practice in Florida

A. Initial Visits and Antepartum Care

Initial Visits and Acceptance into Care:

Total Number of Initial OB Clients Seen: 5,975*
Total Number of Maternity Clients Accepted into Care: 5,722*

**Of 188 reports returned where 2A was greater than 2B.*

Transfers in the Antepartum:

Planned Transfers: 172
 Unplanned Transfers: 268
 Unknown/Other: 35
Total Number of Transfers in the Antepartum: 475

Outliers – Initial Visits / Acceptance into Care Only

Six midwives reported only data in fields 2A (*Total number of initial OB clients seen by you*) and 2B (*Total number of maternity clients you accepted for care in the reporting period*). Their results represent a significant departure from data reported by other midwives:

<i>License</i>	<i>2A (Total number of initial OB clients seen by you)</i>	<i>2B (Total number of maternity clients you accepted for care in the reporting period)</i>
MW90	133	109
MW217	100	100
MW334	46	46
MW347	54	54
MW352	63	63
MW356	59	59

While these midwives are practicing, their results indicate that their practice is limited to intake; they have been excluded from results that survey patterns in intrapartum and postpartum practice.

B. Labor and Delivery; Intrapartum Care

Delivery by Setting:

Midwives are required to report deliveries which they performed. This subset excludes results where the total number of deliveries and delivery by location do not match, as the data cannot be validated as accurate. The total number of midwives whose birth-related data could be included in this subset was 118 of 134 midwives who reported deliveries in 2C and 2E.

Home Deliveries (2E): 1,293*
 Birthing Center Deliveries (2E): 1,151*

Total Reported Deliveries (excluding hospital deliveries): 2,444*

Midwives may attend deliveries in hospitals but would not be considered the primary practitioner. The total reported deliveries below represent the number of confirmed births where a midwife was in attendance, as reported in 2C and 2E, respectively. In total, 28 midwives (23.72%) reported attendance at a hospital birth.

Hospital Deliveries (2E): 108

Total Reported Deliveries (including hospital; midwife attended): 2,552

Breech Births and Multiple Births:

Of the 118 midwives whose birth-related data could be validated in 2C and 2E, seven instances of breech births were reported among five midwives. There were no breech births reported by midwives whose birth-related data could not be validated. Transfer data, included below, indicates that three of the reported breech births occurred in a hospital after transfer. As such, it appears only four breech births occurred under the care of a midwife.

<i>License</i>	<i>Date</i>	<i>Reason</i>	<i>Delivery Method</i>	<i>Complications</i>	<i>Birth Weight</i>	<i>NICU Admit ?</i>	<i>NICU Reason</i>	<i>NICU Days</i>	<i>Death ?</i>
MW17	March 2018	Surprise Breech	C Section	None	7 lb, 10 oz	No	N/A	N/A	No
MW44	10/10/2017	Surprise Breech	C Section	None	7.21 lb	No	N/A	N/A	No
MW265	02/25/2018	Breech	C Section	None	7 lb, 8 oz	No	N/A	N/A	No

One multiple birth was reported by a midwife who reported data in 2C and 2E, and whose birth related data could not be verified.

Planned Vaginal Births after Cesarean Section:

Planned vaginal births after cesarean section (VBAC) are reported in two categories:

Planned Primary VBAC: Primary VBAC is defined as vaginal birth occurring as the next birth after a cesarean section.

Planned Subsequent VBAC: Subsequent VBAC is defined as any vaginal birth occurring after a cesarean section which is not a primary VBAC.

Of the 118 midwives whose birth-related data could be validated, the number of planned primary VBAC and subsequent VBAC were:

<i>Primary VBAC:</i>	60	(38/118 midwives; 32.2%)
<i>Subsequent VBAC:</i>	59	(39/118 midwives; 31.4%)
Total VBAC:	119	

The total number of primary and subsequent VBAC reported were:

<i>Primary VBAC:</i>	76	(42 midwives)
<i>Subsequent VBAC:</i>	76	(44 midwives)
Total VBAC:	152	

Deliveries Completed in Water:

Of the 118 midwives whose birth-related data could be validated, **109 midwives** (92.4%) reported deliveries completed in water.

The total number of deliveries reported as completed in water in this subset was **1,253**, or **51.3%** of the total births.

The total number of midwives reporting deliveries reported as completed in water was **131**. The total number of deliveries reported as completed in water was **1,399**.

Transfers in the Intrapartum:

Total Number of Transfers in the Intrapartum: 343

Number of reported complications after transfer:	53
Number of Reported NICU admissions:	25
Number of deaths reported after transfer in the intrapartum:	4

Transfer data where fetal death was reported after intrapartum transfer. The transfer data below represents outcomes that did not occur under the supervision of a licensed midwife:

Date	Reason	Delivery Method	Complications	Birth Weight
10/23/2017	Fetal distress	C Section	Fetal demise	9 lb, 15 oz
03/26/2018	Fetal distress	C Section	Fetal demise	7 lb, 9 oz
11/01/2017	Non-reassuring FHT	C Section	Fetal demise (9 hours after transfer)	6 lb, 9 oz
03/04/2018	Mec / No FHR	NSVD	Nuchal cord	6 lb, 13 oz

C. Newborn and Maternal Outcomes; Postpartum Care

Mothers Requiring Sutures

Per Rule 64B24-7.008(5), F.A.C., midwives may suture to repair first and second degree lacerations. Of the 118 midwives whose birth-related data could be validated, **95 midwives** (80%) reported providing sutures as part of postpartum care. In total, **572** mothers required sutures following birth. This is approximately **23.4%** of deliveries completed by midwives whose birth-related data could be validated.

The total number of mothers requiring sutures reported was 655.

An additional 22 mothers were transferred postpartum for repair of lacerations of the third or fourth degree. Repair of lacerations outside the scope permitted for midwives' accounts for 30.6% of transfers occurring postpartum:

<i>Date</i>	<i>Reason</i>	<i>Hospital Days</i>	<i>Outcome</i>
6/8/2018	3rd Degree Laceration	0	Stable
5/24/2018	4th degree laceration repair	<1	Laceration repaired DC to home
11/21/2017	3rd Degree Laceration	NA	Sutured as outpatient; excellent
17-Nov	3rd Degree Laceration	0	Good condition
4/25/2018	Repair of extensive laceration 2nd	<1	Stable
9/5/2017	4th degree laceration	2	Uncomplicated; surgical repair
12/15/2017	3rd Degree Tear	10 hours	Tear sutured in OR, clients discharge after suturing was completed
12/11/2017	3rd degree perineal tear	0	Outpatient; repaired
3/28/2018	PPH and 3rd degree laceration	2	Healthy, normal
7/3/2018	3rd degree laceration	2	good / good
2/11/2018	4th degree tear	1	Repaired in OR
11/27/2017	Repair of possible 3" tear	0	Discharge
10/14/2017	3rd degree laceration repair	X	Normal recovery
10/22/2017	3rd degree laceration repair	<1	Normal recovery
2/17/2018	3rd degree laceration repair	1	Normal recovery
9/1/2017	3rd degree laceration	<1	repaired and discharged to home
4/2/2018	3rd laceration	0	repaired - stable
9/5/2017	4th degree laceration	24 hours	OR repair
10/24/2017	3rd degree laceration	6 hours	ER repair
5/13/2018	Cervical tear, prolapse	1	WNL
9/24/2017	3rd degree laceration	not admitted	good
4/18/2018	2nd/3rd degree laceration for repair	<1 (2 hours)	Lac. Repaired & discharged

Newborn Postpartum Transfers

In total, 38 newborn transfers occurring postpartum were reported. 27 of 38 of these transfers resulted in admittance of the newborn to a neonatal intensive care unit (NICU).

One neonatal death was reported after postpartum transfer; transfer data states that the newborn was unresponsive to neonatal resuscitation. This outcome is not reported in Section IV of the report and did not occur under the supervision of the licensed midwife reporting the outcome.



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ANNUAL REPORT OF MIDWIFERY PRACTICE INSTRUCTIONS

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ANNUAL REPORT

SECTION I: The annual report is **not** practice based. Complete this form with your own individual information and data.

SECTION II: Report only data for the previous fiscal year which is July 1 through June 30.

Section 2A should be the total number of clients you saw in the previous fiscal year for an initial or New Client Visit. The number of New Client Visits must be reported even if you are in a group practice. All clients seen should be included, even if you only completed an initial visit and did not accept the client into care or risked the client out of care at the initial visit. The number in Section 2A should include only first visits with a client.

Section 2B should be the total number of clients you accepted into your care. If you have a prescreening process prior to scheduling an appointment, this number may match the total number of initial OB client visits in Section 2A. A client seen for the first initial visit but not accepted into care should not be counted here and should be counted in Section 2A. The number of clients reported in Section 2B can never exceed the number reported under Section 2A.

Section 2C represents the number of babies you delivered as primary midwife. If your name is on the birth certificate as the provider, you should report that delivery here. If you attended a birth as a backup midwife with no other midwife in attendance, that should be counted as a delivery. Those deliveries where you were in attendance with another midwife, but were not the primary midwife or provider should not be reported here.

Section 2D is the total number of licensed student midwives assigned to you during the reporting period. For example, if you supervised one managing student and two observing students you would report three students. Other types of students, such as nursing students, should not be reported. If you are in a group practice you should report the number of students you personally supervised. For example, if all the midwives in a group of four midwives supervised four students, each midwife in the practice should report four students. If a group of three midwives is supervising two students but one midwife only works with one student, the two midwives working with both students would report two and the midwife working with only one student would report one.

Section 2E breaks down the total number of babies you delivered as primary midwife by location of delivery. "Home" is the number of deliveries you attended in the home setting. "Birthing center" is the number of deliveries you attended at a free-standing birthing center. "Hospital" is the number of babies you delivered as primary midwife in a hospital setting. Do not include clients you transferred that delivered at a hospital. For most licensed midwives, the number of hospital deliveries will be zero. The total number of babies delivered reported in Section 2E should match the number of deliveries reported in Section 2C.

Section 2F is the number of unplanned breech and twin/multiple births you personally delivered as primary midwife. Do not include clients you transferred for breech or twin/multiple births. The total should be the number of breech or twin/multiple births added together.

Section 2G is the number of vaginal births after cesarean delivery (VBAC) that were planned during the reporting year. This should include the mothers who would or did deliver during the reporting period. Report a planned VBAC in the reporting period in which the mother will deliver. A primary VBAC are those mothers who have not delivered a baby since their last cesarean section. Subsequent VBACs are those mothers who have had a successful VBAC with the prior pregnancy.

Section 2H should be the total number of deliveries completed in the water. Do not include mothers who only labored in the water.

Section 2I should be the number of mothers who required suturing. Do not include those mothers with minor lacerations who did not require sutures.

Section 3A is the total number of mothers during the reporting period who transferred for medical reasons during pregnancy and prior to admission in labor. Do not include non-medical transfers, such as patient choice or patient relocation. The total in Section 3A should match the total from the Table of Antepartum Transfers.

Section 3B is the total number of mothers transferred to a hospital during their labor, after admission and prior to delivery. This total should match the total from the Table of Intrapartum Transfers. Do not include transfers that occurred when a mother was in labor but was not admitted by the reporting midwife for labor. For example, a mother in pre-term labor who you sent to the hospital would be an antepartum transfer and not an intrapartum transfer. Another example would be a mother in labor at full term with severe bleeding who was sent to the hospital prior to admission for labor which would be an antepartum transfer. A mother in labor and admitted in to your care for delivery who transfers to the hospital would be an intrapartum transfer.

Section 3C is the total number of postpartum transfers for medical reasons. This should include all mothers transferred to the hospital after delivery of the baby and within six weeks of the birth. This total should match the total from the Table of Postpartum Transfers.

Section 3D is the total number of newborn transfers. This should include all newborns transferred to a hospital after delivery and within seven days of birth. This total should match the total from the Table of Newborn Transfers.

Section 4A is the total number of stillborn deliveries you attended. This should not include intrapartum transfer patients who went on to deliver the stillborn at the hospital, which should be counted as an intrapartum transfer. This total should match the total from the Table of Stillbirths.

Section 4B is the total number of neonatal deaths of babies you delivered. This is any fetal death where the baby was born alive but died within seven days of birth. This total should match the total from the Table of Fetal Death/Neonatal Death.

Section 4C is the total number of maternal deaths of clients in your care. A separate report outlining the details of the maternal death should be submitted with the annual report form.

SECTION III. For each of the tables you should document each occurrence during the reporting year. Use the table provided and attach a separate sheet if you need additional lines. Total each table and compare totals to Section II.

Mail completed forms to the Florida Department of Health, Council of Licensed Midwifery, 4052 Bald Cypress Way, Bin #C-06, Tallahassee, FL 32399-3256, or email to MQA.Midwifery@FLHealth.gov.



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ License #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	
	B	Total number of maternity clients you accepted for care in the reporting period:	
	C	Total number of deliveries you performed during reporting period:	
	D	Total number of licensed midwife students assigned to you during the reporting period:	
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____	
	F	Number of unplanned: Breech: _____ Twins / Multiples: _____	
	G	Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____	
	H	Number of water births: _____	
	I	Number of mothers requiring sutures: _____	
	3	A	Number of mothers transferred antepartum (for medical reasons):
		B	Number of mothers transferred intrapartum:
C		Number of mothers transferred postpartum: (medical reasons)	
D		Number of newborn transfers:	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	
	B	Number of fetal deaths / neonatal: (within seven days of birth)	
	C	Number of maternal deaths: (please submit separate report)	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

Signature: _____

Date Signed: _____

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



Annual Report of Midwifery Practice

Department of Health
Florida Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32314-6330

Web: www.floridahealth.gov/licensing-and-regulation/midwifery

E-mail: mqa.midwifery@flhealth.gov

PLEASE NOTE THE FOLLOWING BEFORE COMPLETING YOUR ANNUAL REPORT:

- Report data from July 1st through June 30th of each reporting year.
- The Annual Report of Midwifery Practice is NOT practice based.

Complete this form with your own individual information and data. In group practice settings, please confirm with other midwives in your practice that you are not reporting the same client on multiple reports.

Section I. General Information

Midwife Name: _____ License Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (____) - ____ - _____

Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request, do not provide an email address or send electronic mail to the Department. The Department may be reached by telephone or in writing.

Section II. Practice Information

1. How long did you practice in the previous reporting year?

Please choose only one of the following options.

- I did not practice midwifery in Florida this year.
- I practiced for one to three months in Florida this year.
- I practiced four to six months in Florida this year.
- I practiced seven to nine months in Florida this year.
- I practiced ten to twelve months in Florida this year.

2. Which of the following best describes your practice setting?

Please choose only one of the following options.

- I work exclusively in my own practice.
- I work exclusively in a free-standing birthing center or group practice:
Name of Facility/Practice: _____ License: _____
- I work in my own practice and in a free-standing birthing center or group practice:
Name of Facility/Practice: _____ License: _____
- Other (please specify): _____

Section III. Student Midwives

3. Number of student midwives supervised during the reporting period: _____

Include **all** student midwives you supervised in **any** capacity during the reporting period (managing, observing, etc.). In a group practice setting, report all student midwives you supervised, even if the student midwife was also supervised by another midwife or midwives in your practice. **Do not** include other types of students supervised during the reporting period (nurses, etc.).

Section IV. Initial / New Client Visits / Collaborative Management

4. Number of clients seen for an initial or new client visit: _____

Include **all** clients you saw during the reporting period, even if the client was not accepted into care or could not be accepted into care due to a risk factor score and determination by a physician pursuant to 64B24-7.004, F.A.C. that the client could not be expected to have a normal pregnancy. If you are in a group practice setting, include all clients which you saw during the reporting period.

5a. Number of clients accepted into your care: _____

Include **only** clients accepted into your care. If you prescreen prior to an initial visit, this number may coincide with the number reported in 4, above.

5b. Number of clients accepted for care who plan to deliver with another provider: _____

Include **only** clients accepted into your care who do not intend to deliver with you, or in your group practice setting if applicable. This may include clients who enter collaborative management, or clients who do not enter collaborative management but who plan to deliver in a hospital or other similar setting.

5c. Number of collaborative management clients: _____

Include **only** clients where you entered collaborative management with a physician.

Section V. Delivery

Deliveries by Provider / Role:

6a. Deliveries made as the primary midwife: _____

Include **only** deliveries where you were the primary midwife; if your name appears on the birth certificate as the provider, the delivery should be reported here.

6b. Deliveries made as a backup midwife: _____

Include **only** deliveries where you attended as a backup midwife with **no other midwife** in attendance.

Deliveries by Location (Primary Midwife):

The total number of deliveries reported in 7a, 7b, and 7c should be equal to the number of deliveries reported in 6a. Include **only** births where you were the primary midwife.

7a. Number of births attended in a home: _____

7b. Number of births attended in a birthing center: _____

7c. Number of births attended in a hospital: _____

Vaginal Births after Cesarean Delivery (VBAC):

Include deliveries which occurred **during** the reporting period. **Do not** include deliveries which were planned but did not occur during the reporting period.

9a. Number of Primary VBAC: _____

A primary VBAC is a delivery in which the mother has not delivered since a previous cesarean section.

9b. Number of Secondary VBAC: _____

A secondary VBAC is a delivery in which the mother has delivered vaginally since a previous caesarian section.

Unplanned Deliveries (Primary Midwife):

Include **only** breech and twin/multiple births where you were the primary midwife. **Do not** include clients you transferred for breech or twin/multiple births. This number should not exceed the number of deliveries reported in 6a.

8a. Number of unplanned breech births: _____

8b. Number of unplanned twin/multiple births: _____

Water Births and Mothers Requiring Sutures:

10. Number of Births Completed in Water: _____

Include **only** births which were completed in the water; do not include births where only a portion of labor occurred in the water.

11. Number of Mothers Requiring Sutures: _____

Include **only** mothers requiring sutures; do not include mothers with minor lacerations who did not require sutures.

Section VI. Transfers

10. Antepartum Transfers for Medical Reasons (table):

Include **all** mothers who transferred for medical reasons during pregnancy and prior to admission in labor. Do not include transfers completed for non-medical reasons, including client choice or relocation.

Date	Reason for Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Method (if known) - NSVD, VAC, Forceps, C/S
Total Number of Antepartum Transfers:				

Postpartum Transfers - Maternal and Newborn:

12a. Maternal Transfers (table):

Include **all** mothers who transferred after delivery for medical reasons and within six weeks after birth.

Date	Reason for Transfer	Days in Hospital	Outcome/Condition on Discharge
Total Number of Maternal Postpartum Transfers:			

12b. Newborn Transfers (table):

Include **all** newborns who transferred to a hospital after delivery and within seven days after birth.

Date	Reason for Transfer	Birth Weight	APGARS	Admitted to NICU? (if "Yes," include reason and number of days)	Outcome/Condition on Discharge
Total Number of Newborn Postpartum Transfers:					

Section VII. Deaths

12. Stillbirth:

Include **only** stillborn deliveries you attended as the primary midwife. **Do not** include mothers transferred intrapartum who delivered stillborn at the hospital.

Date	Reason for Transfer	Birth Weight	APGARS	Admitted to NICU? (if "Yes," include reason and number of days)	Outcome/Condition on Discharge
Total Number of Stillbirths:					

13. Fetal Death:

Include **all** fetal deaths that occurred where you attended the birth as the primary midwife.

Date	Cause of Death	Site of Death	Gestational Age
Total Number of Fetal / Neonatal Deaths:			

14. Neonatal Death:

Include **all** neonatal deaths that occurred within 7 days of the birth where you attended the birth as the primary midwife.

Date	Cause of Death	Site of Death	Gestational Age
Total Number of Fetal / Neonatal Deaths:			

15. Maternal Death:

Include all deaths occurring within seven days of birth following delivery, where you attended the birth as the primary midwife.

Total Number of Maternal Deaths:	
---	--

For all reported maternal deaths, please attach a separate, detailed report of the incident.

Section VIII. Affirmation

I have participated in giving information for the purpose of gathering statistics for Licensed Midwives in the state of Florida, pursuant to 64B24-7.014(6), F.A.C. I understand that the Council of Licensed Midwifery uses this information to prepare the Midwifery Annual Report.

I affirm that the information provided is true and correct.

Name (print): _____ Date: _____

Signature: _____

COLLABORATIVE MANAGEMENT AGREEMENT

Name of Licensed Midwife: _____

Address: _____

Office Phone: _____ Beeper No.: _____

Physician Name: _____

Address: _____

Office Phone: _____ Beeper No.: _____

Hospital Affiliation: _____

Address: _____

Hospital Phone: _____ ER Phone: _____ L&D Phone: _____ NU: _____

Patient's Name: _____

Address: _____

Home Phone: _____ Office Phone: _____

Age: _____ Gravida/Para: _____ EDD: _____

Patient Risk Factors: _____

Rationale for Deviation from Low Risk Criteria: _____

Management of Care Plan: _____

Expected Outcome: _____

Criteria to Discontinue Collaborative Agreement: _____

On _____, _____ hereby
(Date) (Midwife's Signature)

entered into an agreement to provide collaborative prenatal/postpartum care to

_____ with _____
(Patient's Signature) (Physician's Signature)

who will direct and supervise the course of medical management as specified above.

Discontinued On: _____
(Date) (Patient's Signature)

(Midwife's Signature) (Physician's Signature)

Explanation of Discontinuation: _____



Collaborative Management Agreement

Florida Council of Licensed Midwifery

4052 Bald Cypress Way, Bin C-06

Tallahassee, FL 32314-6330

Web: <http://www.floridahealth.gov/licensing-and-regulation/midwifery/>

E-mail: MQA.Midwifery@flhealth.gov

Section I. Midwife / Physician Contact Information

Name of Licensed Midwife: _____ License Number: _____

Address: _____

Office Phone: _____

Name of Physician: _____

Address: _____

Office Phone: _____

Section II. Hospital Contact Information

Hospital Affiliation: _____

Address: _____

Hospital Phone: _____ Emergency Room Phone: _____

Labor and Delivery Phone: _____ Neonatal Unit Phone: _____

Section III. Patient Information

This section is confidential and exempt from disclosure.

Patient's Name: _____ Age: _____

Address: _____

Primary Phone (Home/Cell): _____ Work Phone: _____

Gravida/Para: _____ Estimated Due Date: _____

Patient Risk Factors: _____

Rationale for Deviation from Low Risk Criteria: _____

Management of Care Plan: _____

Expected Outcome: _____

Criteria to Discontinue: _____

Section IV. Signatures

On _____, _____
 (Date) (Midwife's Name)

hereby entered into an agreement to provide collaborative prenatal/postpartum care to

_____ with _____
 (Patient's Name) (Physician's Name)

who will direct and supervise the course of medical management as specified in this collaborative agreement.

 (Midwife's Signature) (Date)

 (Physician's Signature) (Date)

 (Patient's Signature) (Date)

Section V. Discontinuation of Collaborative Management

Collaborative Management Discontinued on: _____
 (Date)

Explanation of Discontinuation:

 (Midwife's Signature) (Date)

 (Physician's Signature) (Date)

 (Patient's Signature) (Date)

INFORMED CONSENT FOR LICENSED MIDWIFERY SERVICES

Client's Name: _____

First Middle Maiden Last

Address: _____

Street City State Zip

Date of Birth: ____ / ____ / ____

Telephone Number: _____

GRAVIDA _____

Para ____ / ____ / ____

EDD ____ / ____ / ____

CONSENT:

I acknowledge that I am contracting for the services of a licensed midwife. I understand that licensed midwives provide care for women who have normal, uncomplicated pregnancies and expect a normal delivery of a healthy child. The educational background, training and experience of Florida licensed midwives varies. The licensed midwife listed below has explained her training and experience to me.

In order to receive care by the midwife, I must do the following:

- ❖ Give a complete medical, health and maternity history
- ❖ Review risk factors and other requirements with my midwife.
- ❖ Maintain a regular schedule for prenatal visits.
- ❖ I must make a plan for emergency care, with the assistance of the midwife. This plan will be implemented should unforeseen complications arise during my pregnancy or deliver. Further, the plan shall include any pediatric care necessary for my baby.

Childbearing is a normal human function, however unpredictable medical problems may arise during pregnancy or childbirth. Because some of these problems may place my child or myself at risk, transfer to a physician and/or hospital may be necessary. Delay in treatment may increase the degree of complication(s). Conditions that may be life threatening and/or require transfer to a hospital, are, but not limited to, symptoms of fetal distress, severe tears of the perineal area, excessive blood loss, seizures, abruption of the placenta, prolapsed cord or uterine rupture.

I am also aware of the benefits of natural childbirth relating to avoidance of potential injury resulting from either invasive procedures, anesthesia, or surgical intervention.

I have had an opportunity to review and discuss the information contained in this consent form; including, but not limited to the conditions which require the midwife to refer and/or transfer my care and responsibilities while under the midwife's care.

I hereby affirm that the licensed midwife presented to me the status of the midwife's malpractice insurance, including the amount of insurance, if any. Yes _____ No _____

I hereby attest to the given accuracy of my medical and obstetrical history and agree to adhere to the listed conditions, but not limited to, in this consent form.

I HEREBY AUTHORIZE _____, LICENSED MIDWIFE, TO PERFORM THOSE MATERNITY SERVICES WHICH ARE WITHIN THE SCOPE OF THE MIDWIFERY LIENSE. A COPY OF CHAPTER 467, FLORIDA STATUTES, AND 64B24, FLORIDA ADMINISTRATIVE CODE, OUTLINING THE SCOPE AND QUALIFICAITONS OF THE MIDWIFERY LIENSE ARE AVAILABLE UPON REQUEST.

Signature of Client

Date Accepted Licensed Midwife for Services

Signature of Licensed Midwife

Date Accepted Client for Services

Printed name of Licensed Midwife

License number

64B24-7.004 Risk Assessment.

(1) For each patient, the licensed midwife shall assess risk status criteria for acceptance and continuation of care. The general health status and risk assessment shall be determined by the licensed midwife by obtaining a detailed medical history, performing a physical examination, and taking into account family circumstances along with social and psychological factors. The licensed midwife shall risk screen potential patients using the criteria in this section. If the risk factor score reaches 3 points the midwife shall consult with a physician who has obstetrical hospital privileges and if there is a joint determination that the patient can be expected to have a normal pregnancy, labor and delivery the midwife may provide services to the patient. When a client has a risk score of 3 or higher and has previously had a physician consultation for the identical risk factors in a prior pregnancy with no current changes in health or risk factors another consultation is not required.

(2) The licensed midwife shall continue to evaluate a patient during the antepartum, intrapartum and postpartum. If the cumulative risk score reaches three points or higher and the patient is not expected to have a normal pregnancy, labor and delivery, the midwife shall transfer such patient out of his or her care. The midwife may provide collaborative care to the patient pursuant to Rule 64B24-7.010, F.A.C.

(3) The risk factors shall be scored as follows: Score

(a) Socio-Demographic Factors.

- | | |
|---|---|
| 1. Chronological age under 16, or older than 40. | 1 |
| 2. Residence of anticipated birth more than 30 minutes from emergency care. | 3 |

(b) Documented Problems in Maternal Medical History.

1. Cardiovascular System.

- | | |
|--|---|
| a. Chronic hypertension. | 3 |
| b. Heart disease. | 3 |
| c. Heart disease assessed by a cardiologist which places the mother or fetus at no risk. | 1 |
| d. Pulmonary embolus. | 3 |
| e. Congenital heart defects. | 3 |
| (i) Congenital heart defects assessed by a cardiologist which places the mother or fetus at no risk. | 1 |

2. Urinary System.

- | | |
|-------------------------------|---|
| a. Renal disease. | 3 |
| b. History of pyelonephritis. | 1 |

3. Psycho-Neurological.

- | | |
|--|---|
| a. History of psychotic episode adjudged by psychiatric evaluation and which required use of drugs related to its management, but not currently on medication. | 1 |
| b. Current mental health problems. | |
| Requiring drug therapy. | 3 |
| c. Epilepsy or seizures in the last two years. | 3 |
| d. Required use of anticonvulsant drugs. | 3 |

- e. During the current pregnancy, drug or alcohol addiction, use of addicting drugs. 3
- f. Severe undiagnosed headache. 3

4. Endocrine System.

- a. Diabetes mellitus. 3
- b. History of gestational diabetes. 1
- c. Current thyroid disease.
 - (I) Euthyroid. 1
 - (II) Non-Euthyroid. 3

5. Respiratory System.

- a. Chronic bronchitis. 1
 - (I) Current or chronic or with medication. 3
 - (II) Without medication or current problems. 1
- b. Smoking.
 - (I) 10 or less cigarettes per day. 1
 - (II) More than 10 cigarettes per day. 3

6. Other Systems.

- a. Bleeding disorder or hemolytic disease. 3
- b. Cancer of the breast in the past five years. 3

7. Documented Problems in Obstetrical History

- a. Expected Date of Delivery (EDD) less than 12 months from date of previous delivery. 1
- b. Previous Rh sensitization. 3
- c. 5 or more term pregnancies. 3
- d. Previous abortions.
 - (I) 3 or more consecutive spontaneous abortions. 3
 - (II) Two consecutive spontaneous abortions or more than three spontaneous abortions. 1
 - (III) 1 septic abortion. 3
- e. Uterus.
 - (I) Incompetent cervix, with related medical treatment. 3
 - (II) Prior uterine surgery. 3
 - (III) Prior uterine surgery followed by an uncomplicated vaginal birth. 2

- f. Previous placenta abruptio. 3
- g. Previous placenta previa. 1
- h. Severe pregnancy induced hypertension during last pregnancy. 2
- i. Postpartum hemorrhage apparently unrelated to management. 3

8. Physical Findings of Previous Births

- a. Stillbirth occurring at more than 20 weeks gestation or neonatal loss (other than cord accident). 3
- b. Birthweight.
 - (I) Less than 2500 grams or two or more previous premature labors without a subsequent low risk pregnancy and full term appropriate for gestational age (AGA) infant. 3
 - (II) Less than 2500 grams or two or more previous premature labors with one or more full term AGA infant(s) subsequently delivered, after a low risk pregnancy. 1
 - (III) More than 4000 grams. 1
- c. Major congenital malformations, genetic, or metabolic disorder. 3

9. Maternal Physical Findings.

- a. Gestation.
 - (I) Of more than 22 weeks in the patient's first pregnancy (nullipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care. 3
 - (II) Of more than 28 weeks if the patient has had at least one previous viable birth (multipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care. 3
- b. Prepregnant weight is not within the range of the following weights by height: 2

Height in Inches Without Shoes	Prepregnant Minimum Weight in Pounds	Prepregnant Maximum Weight in Pounds
56	83	143
57	85	146
58	86	150
59	89	153
60	92	157
61	95	161
62	97	166
63	100	170
64	103	175
65	106	180

66	110	185
67	113	190
68	117	196
69	121	202
70	124	208
71	128	212
72	131	217
73	135	222

- c. Evidence of clinically diagnosed pathological uterine myoma or malformations, abdominal or adnexal masses. 3
- d. Polyhydramnios or oligohydramnios.
 - (I) Prior pregnancy. 2
 - (II) Current pregnancy. 3
- e. Cardiac diastolic murmur, systolic murmur grade III or above, or cardiac enlargement. 3

10. Current Laboratory Findings.

- a. Hematocrit/Hemoglobin.
 - (I) Less than 31% or 10.3 gm/100 ml. 1
 - (II) Less than 28% or 9.3 gm/100 ml. 3
- b. Sickle cell anemia. 3
- c. Pap smear suggestive of dysplasia. 3
- d. Evidence of active tuberculosis. 3
- e. Positive serologic test for syphilis confirmed active. 3
- f. HIV positive. 3

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History—New 7-14-94, Formerly 61E8-7.004, 59DD-7.004, Amended 9-11-02, 2-2-06, 4-1-09.



Adverse Incident Report for Planned Out-of-Hospital Births Florida Department of Health

Submit form to:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275

Part I: Practitioner Information

456.0495, Florida Statutes, requires the reporting of all adverse incidents which occur during planned out-of-hospital births. **This form does not replace any other adverse incident reporting required by the statutes and rules which govern your specific profession.**

Practitioner Name: _____
License Number: _____

Part II: Adverse Incident (General Information)

Incident Date: _____ Incident Time: _____

Address of incident: _____

City: _____ State: _____ Zip: _____

This address is a:

- Home/Private Residence
- Physician's Office (specify office registration number): _____
- Birthing Center (specify name): _____
- Other (please specify): _____

Please indicate all which apply:

- A maternal death occurred during delivery.
- A maternal death occurred within 42 days after delivery.
- The maternal patient was transferred to a hospital intensive care unit.
- The maternal patient experienced hemorrhagic shock.
- The maternal patient required a transfusion of more than 4 units of blood or blood products.

- A fetal or newborn death occurred associated with obstetrical delivery.
 - Y N The fetal or newborn death was a stillbirth.
- The newborn was transferred to neonatal intensive care due to a traumatic physical or neurological birth injury.
 - Y N This transfer occurred due to a brachial plexus injury.
- The newborn was transferred to a neonatal intensive care unit within the first 72 hours after birth.
 - Y N The newborn remained in neonatal intensive care for more than 72 hours.

If the incident involved a death:

- Y N The Medical Examiner was notified.
- Y N An autopsy was performed.

New Reporting Requirements (Senate Bill 510)

Senate Bill 510 was approved by Governor Scott on March 19th, 2018. This legislation provides requirements for the reporting of adverse incidents in planned out-of-hospital births under the Medical Practice Act (Section 456.0495, Florida Statutes).

Who is affected?

- Medical Doctors (*Chapter 458, F.S.*)
- Doctors of Osteopathic Medicine (*Chapter 459, F.S.*)
- Certified Nurse Midwives (*Chapter 464, F.S.*)
- Licensed Midwives (*Chapter 467, F.S.*)

What will be required?

Beginning July 1st, 2018, you will be required to report adverse incidents occurring in planned out-of-hospital births to the Department within 15 days after the adverse incident.

To report these incidents, you will be required to use a form provided by the Department. This form will be linked to this page when it becomes available.

What is considered an adverse incident during a planned out-of-hospital birth?

456.0495(1)(a) – (g), Florida Statutes (2018) lists these occurrences as adverse incidents:

- A maternal death that occurs during delivery or within 42 days after delivery
- The transfer of a maternal patient to a hospital intensive care unit
- A maternal patient experiencing hemorrhagic shock or requiring a transfusion of more than 4 units of blood or blood products
- A fetal or newborn death, including a stillbirth, associated with obstetrical delivery
- A transfer of a newborn to a neonatal intensive care unit due to a traumatic physical or neurological birth injury, including any degree of a brachial plexus injury
- A transfer of a newborn to a neonatal intensive care unit within the first 72 hours after birth if the newborn remains in such unit for more than 72 hours

What's next?

The Department is drafting forms and rules to implement the provisions in Section 456.0495, F.S.

Where can I find more information?

This page will be updated as information becomes available.

To read the full text of the bill, visit:

- [The Florida Senate \(CS/CS/SB 510: Reporting of Adverse Incidents in Planned Out-of-hospital Births\)](#)

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Cathy Matthews License #: MW 7
 Practice Name: Homebirth Services
 Address: 4944 Midnight Ln
Sarasota FL 34235
 Phone Number: 941 351 2102 Email: clynnem77@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2	
A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care): 17
B	Total number of maternity clients you accepted for care in the reporting period: 17
C	Total number of deliveries you performed during reporting period: 15
D	Total number of licensed midwife students assigned to you during the reporting period: 0
E	How many delivered at: Home: 15 Birthing Ctr: 0 Hospital: 4
F	Number of unplanned: Breech: 0 Twins / Multiples: 0
G	Number of planned VBAC: 1 # of primary VBAC: 1 # of subsequent VBAC: 0
H	Number of water births: 3
I	Number of mothers requiring sutures: 7
3	
A	Number of mothers transferred antepartum (for medical reasons): 0
B	Number of mothers transferred intrapartum: 4
C	Number of mothers transferred postpartum: (medical reasons) 0
D	Number of newborn transfers: 1
4	
A	Number of fetal deaths / stillborn: (midwife delivery only) 0
B	Number of fetal deaths / neonatal: (within 7 days of life) 0
C	Number of maternal deaths: (please submit separate report) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

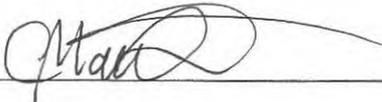
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Cathy Matthews

Signature: 

Date: 07-31-18



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Justine Clegg **License #:** MW11
Practice Name: _____
Address: 5708 SW 69th Avenue, Miami, FL 33143

Phone Number: 305-310-4507 **Email:** justineclegg@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:				0	
	B	Total number of maternity clients you accepted for care in the reporting period:				0	
	C	Total number of deliveries you performed during reporting period:				0	
	D	Total number of licensed midwife students assigned to you during the reporting period:				0	
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:	
	F	Number of unplanned: Breech:		Twins / Multiples			
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		
	H	Number of water births:				0	
	I	Number of mothers requiring sutures:				0	
3	A	Number of mothers transferred antepartum (for medical reasons):				0	
	B	Number of mothers transferred intrapartum:				0	
	C	Number of mothers transferred postpartum: (medical reasons)				0	
	D	Number of newborn transfers:				0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)				0	
	C	Number of maternal deaths: (please submit separate report)				0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

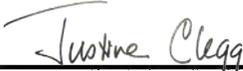
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Justine Clegg

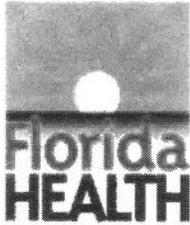
Signature: 

Date Signed: July 21, 2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

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SECTION I: PRACTICE INFORMATION

Midwife Name: Sharon Hamilton L.M. License #: MW16

Practice Name: _____

Address: 2148 Tyler St
Hollywood FL 33020

Phone Number: 954 581-8126 Email: hamilton_256731@bellsouth.net

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					11
	B	Total number of maternity clients you accepted for care in the reporting period:					11
	C	Total number of deliveries you performed during reporting period:					8
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
E	How many delivered at: Home:		8	Birthing Ctr:	0	Hospital:	0
	F Number of unplanned: Breech:		0	Twins / Multiples	0		
G	Number of planned VBAC:		# of primary VBAC:	# of subsequent VBAC:			
	H Number of water births:						3
3	I	Number of mothers requiring sutures:					2
	A	Number of mothers transferred antepartum (for medical reasons):					1
	B	Number of mothers transferred intrapartum:					2
	C	Number of mothers transferred postpartum: (medical reasons)					0
4	D	Number of newborn transfers:					0
	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
6-21-18	Miscarriage	Unplanned	21	Miscarriage

Total Number of Antepartum Transfers from all sheet (3-A) **1**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
9-1-17	Failure to progress	NSVD	none	8lb2oz	No	No
10-24-17	Premature Rupture Membranes	NSVD	none	6lb12oz	No	No

Total Intrapartum Transfers from all sheets (3-B) **2**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Sharon Hamilton

Signature: *Sharon Hamilton*

Date Signed: 7-30-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
 MQA.Midwifery@FIHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jarice Heller License #: MW17
 Practice Name: Conscious Childbirth Inc
 Address: 4006 E Sailboat Dr
Cooper City Fla 33026
 Phone Number: 954 922 2400 Email: shantrose@aol.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2 A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <u>21</u>
B	Total number of maternity clients you accepted for care in the reporting period: <u>17</u>
C	Total number of deliveries you performed during reporting period: <u>15</u>
D	Total number of licensed midwife students assigned to you during the reporting period: <u>0</u>
E	How many delivered at: Home: <u>14</u> Birthing Ctr: <u>1</u> Hospital: <u>2</u> <u>17</u>
F	Number of unplanned: Breech: <u>1</u> Twins / Multiples: <u>1</u>
G	Number of planned VBAC: # of primary VBAC: <u>1</u> # of subsequent VBAC: <u>1</u> <u>2</u>
H	Number of water births: <u>10</u>
I	Number of mothers requiring sutures: <u>0</u>
3 A	Number of mothers transferred antepartum (for medical reasons): <u>1</u>
B	Number of mothers transferred intrapartum: <u>1</u>
C	Number of mothers transferred postpartum: (medical reasons) <u>0</u>
D	Number of newborn transfers: <u>0</u>
4 A	Number of fetal deaths / stillborn: (midwife delivery only) <u>0</u>
B	Number of fetal deaths / neonatal: (within 7 days of life) <u>0</u>
C	Number of maternal deaths: (please submit separate report) <u>0</u>

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(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
∅	∅	∅	∅

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
∅	∅	∅	∅	∅	∅

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
∅	∅					

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
∅	∅			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
∅	Total Number of Maternal Deaths (4-C)

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Printed Name: JANICE HELLER
 Signature: Janice Heller
 Date Signed: June 13 / 2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
 MQA.Midwifery@FIHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: D. LYNNE SALZBURG **License #:** MW 20
Practice Name: MIDWIVES COOPERATIVE LLC
Address: 2602 NW 6th Street, Ste B, Gainesville, FL 32609
Phone Number: 352 377 3879 **Email:** midwivescooperative@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					11
	B	Total number of maternity clients you accepted for care in the reporting period:					11
	C	Total number of deliveries you performed during reporting period:					4
	D	Total number of licensed midwife students assigned to you during the reporting period:					2
E	How many delivered at: Home:	4	Birthing Ctr:	0	Hospital:	0	
F	Number of unplanned: Breech:	0	Twins / Multiples	0			
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		
H	Number of water births:					0	
I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					9
	B	Number of mothers transferred intrapartum:					2
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	NONE		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	NONE		/ / / / /		
			/ / / / /		
			/ / / / /		
			/ / / / /		
			/ / / / /		
			/ / / / /		
			/ / / / /		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NONE					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

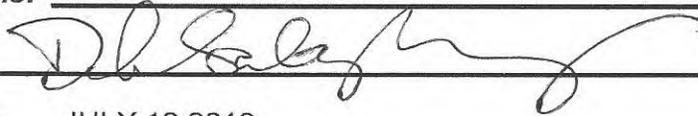
Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NONE			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: D. LYNNE SALZBURG

Signature: 

Date Signed: JULY 12 2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Maria Milton License #: MW26
 Practice Name: Milton Memorial Birthing Center
 Address: 952 Flower View Boulevard
Neapel Hill, FL 32567
 Phone Number: 850-834-2946 Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 12
	B	Total number of maternity clients you accepted for care in the reporting period: 12
	C	Total number of deliveries you performed during reporting period: 5
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 0 Birthing Ctr: 5 Hospital: 1 6
F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0	
G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0 0	
H	Number of water births: 0	
I	Number of mothers requiring sutures: 3	
3	A	Number of mothers transferred antepartum (for medical reasons): 0
	B	Number of mothers transferred intrapartum: 1
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

*MARIA MILTON

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.) *NONE*

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.) *NONE*

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only) *NONE*

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

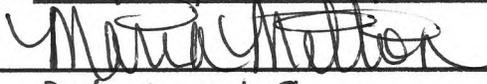
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: MARIA MILTON

Signature: 

Date Signed: 07-27-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

0-Florida Births

SECTION I: PRACTICE INFORMATION

Midwife Name: Carol Ann Nelson License #: 27

Practice Name: The Farm Midwifery Center

Address: 198 Second Rd
Summertown, TN 38483

Phone Number: 931-964-2589 Email: cpmchel@usf.net

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	<i>Not practicing in Florida</i>				Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:			
	B	Total number of maternity clients you accepted for care in the reporting period:			
	C	Total number of deliveries you performed during reporting period:			
	D	Total number of licensed midwife students assigned to you during the reporting period:			
	E	How many delivered at: Home:	Birthing Ctr:	Hospital:	
	F	Number of unplanned: Breech:	Twins / Multiples		
	G	Number of planned VBAC:	# of primary VBAC:	# of subsequent VBAC:	
	H	Number of water births:			
	I	Number of mothers requiring sutures:			
	3	A	Number of mothers transferred antepartum (for medical reasons):		
B		Number of mothers transferred intrapartum:			
C		Number of mothers transferred postpartum: (medical reasons)			
D		Number of newborn transfers:			
4	A	Number of fetal deaths / stillborn: (midwife delivery only)			
	B	Number of fetal deaths / neonatal: (within seven days of birth)			
	C	Number of maternal deaths: (please submit separate report)			

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)

Total Number of Antepartum Transfers from all sheet (3-A) 0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?

Total Intrapartum Transfers from all sheets (3-B) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Carol Ann Nelson
Signature: Carol A. Nelson
Date Signed: 08-01-2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Lillian A Sannere License #: MW 31
 Practice Name: The Birth Cottage
 Address: 260 E 6 Ave
Tallahassee, FL 32303
 Phone Number: 850-224-2229 Email: BirthCottage@yahoo.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care): <u>65</u>
	B	Total number of maternity clients you accepted for care in the reporting period: <u>65</u>
	C	Total number of deliveries you performed during reporting period: <u>35</u>
	D	Total number of licensed midwife students assigned to you during the reporting period: <u>3</u>
	E	How many delivered at: Home: <u>10</u> Birthing Ctr: <u>25</u> Hospital: <u>0</u> <u>35</u>
F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u> <u>0</u>	
G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u> <u>0</u>	
H	Number of water births: <u>8</u>	
I	Number of mothers requiring sutures: <u>8</u>	
3	A	Number of mothers transferred antepartum (for medical reasons): <u>0</u>
	B	Number of mothers transferred intrapartum: <u>0</u>
	C	Number of mothers transferred postpartum: (medical reasons) <u>1</u>
	D	Number of newborn transfers: <u>1</u>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <u>0</u>
	B	Number of fetal deaths / neonatal: (within 7 days of life) <u>0</u>
	C	Number of maternal deaths: (please submit separate report) <u>0</u>

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(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

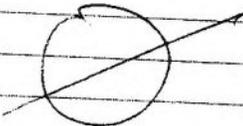
Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
6/8/18	3° Laceration	0	Stable
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
4/27/18	RDS	716g	7 8	8	Stable
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
						
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Lillian Alicia Sanpere

Signature: Lillian A. Sanpere

Date: 7-3-18.



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

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SECTION I: PRACTICE INFORMATION

Midwife Name: Patricia L. Starkman License #: mw33

Practice Name: _____

Address: 2030 S. Douglas Rd. Apt. 815
Coral Gables, FL 33134

Phone Number: 954-559-0062 Email: starkman331@aol.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	0
	B	Total number of maternity clients you accepted for care in the reporting period:	
	C	Total number of deliveries you performed during reporting period:	
	D	Total number of licensed midwife students assigned to you during the reporting period:	
	E	How many delivered at: Home: <input type="text"/> Birthing Ctr: <input type="text"/> Hospital: <input type="text"/>	
	F	Number of unplanned: Breech: <input type="text"/> Twins / Multiples: <input type="text"/>	
	G	Number of planned VBAC: <input type="text"/> # of primary VBAC: <input type="text"/> # of subsequent VBAC: <input type="text"/>	
	H	Number of water births: <input type="text"/>	
	I	Number of mothers requiring sutures: <input type="text"/>	
	3	A	Number of mothers transferred antepartum (for medical reasons):
B		Number of mothers transferred intrapartum:	
C		Number of mothers transferred postpartum: (medical reasons)	
D		Number of newborn transfers:	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	
	B	Number of fetal deaths / neonatal: (within seven days of birth)	
	C	Number of maternal deaths: (please submit separate report)	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Patricia L. Starkman
 Signature: *Patricia L. Starkman*
 Date Signed: 7/12/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Michelle Hannah License #: 34
 Practice Name: Celebrate Birth
 Address: 1525 Edgewater Beach Dr.
Lakeland, FL 33805
 Phone Number: 863.680.2229 Email: celebratebirth@live.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 56
	B	Total number of maternity clients you accepted for care in the reporting period: 135
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period: 30
E	How many delivered at: Home: 5 Birthing Ctr: 25 Hospital: 0 30	
F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0	
G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 2 2	
H	Number of water births: 4	
I	Number of mothers requiring sutures: 9	
3	A	Number of mothers transferred antepartum (for medical reasons): 8
	B	Number of mothers transferred intrapartum: 4
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

0

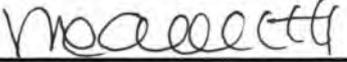
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Michelle Hannah
Signature: 
Date Signed: 7/20/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

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 Tallahassee, FL 32399-3256
 MQA.Midwifery@FIHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Shirley J Tregillus License #: MW35
 Practice Name: Countryside Birthing Place, Inc.
 Address: 3060 Jones Lane Clearwater, Fl. 33579
 Phone Number: 727-452-2440 cell Email: countrysidebp@yahoo.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 11
	B	Total number of maternity clients you accepted for care in the reporting period: 11
	C	Total number of deliveries you performed during reporting period: 7
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 0 Birthing Ctr: 7 Hospital: 0 7
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0
	G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0 0
	H	Number of water births: 7
	I	Number of mothers requiring sutures: 0
3	A	Number of mothers transferred antepartum (for medical reasons): 2
	B	Number of mothers transferred intrapartum: 0
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within 7 days of life) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	None		

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	None				

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	None					

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	None			
Total Number of Fetal/Neonatal Deaths (4-B)				()

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and

Printed Name: Shirley J. Tregillus

Signature: *Shirley J. Tregillus L.M.*

Date Signed: July 31, 2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FIHealth.gov



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Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ License #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____
	F	Number of unplanned: Breech: _____ Twins / Multiples: _____
	G	Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____
	H	Number of water births:
	I	Number of mothers requiring sutures:
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

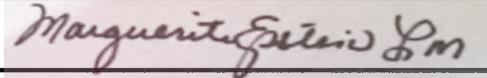
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

Signature:  _____

Date Signed: _____

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Deborah Marin License #: mw 44
 Practice Name: Hollywood Birth Center
 Address: 2316 Hollywood Blvd
Hollywood, FL 33020
 Phone Number: (954) 925-4499 Email: info@hollywoodBirthcenter.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					422
	B	Total number of maternity clients you accepted for care in the reporting period:					350
	C	Total number of deliveries you performed during reporting period:					12
	D	Total number of licensed midwife students assigned to you during the reporting period:					2
	E	How many delivered at:	Home: 5	Birthing Ctr: 7	Hospital: 0		12
	F	Number of unplanned:	Breech: 1	Twins / Multiples: 0			
	G	Number of planned VBAC:	# of primary VBAC: 1	# of subsequent VBAC: 1			2
	H	Number of water births:					8
	I	Number of mothers requiring sutures:					2
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					1
	D	Number of newborn transfers:					1
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
10/10/17	Surprise breech	C-section	none	7.21lbs	no	no

Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
6/25/18	Hemorrhage	1	WNL

Total Number of Postpartum Transfers from all sheets (3-C) 1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
6/25/18	Grunting	10.8	8	2	W Normal

Total Newborn Transfers from all sheets(3-D) 1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Ad. Deborah marin

Signature: Deborah Marin

Date Signed: 7/19/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

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SECTION I: PRACTICE INFORMATION

Midwife Name: Connie Mullen License #: 45
 Practice Name: Zion Birthing Ministries
 Address: 612 NW 15 Avenue
Boca Raton FL 33486
 Phone Number: 561-330-0993 Email: BABCATCHER@AOL.COM

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <u>3</u>	
	B	Total number of maternity clients you accepted for care in the reporting period: <u>3</u>	
	C	Total number of deliveries you performed during reporting period: <u>2</u>	
	D	Total number of licensed midwife students assigned to you during the reporting period: <u>0</u>	
	E	How many delivered at: Home: <u>2</u> Birthing Ctr: <u>0</u> Hospital: <u>0</u> <u>2</u>	
	F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>	
	G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u> <u>0</u>	
	H	Number of water births: <u>0</u>	
	I	Number of mothers requiring sutures: <u>0</u>	
	3	A	Number of mothers transferred antepartum (for medical reasons): <u>0</u>
		B	Number of mothers transferred intrapartum: <u>0</u>
C		Number of mothers transferred postpartum: (medical reasons) <u>0</u>	
D		Number of newborn transfers: <u>0</u>	
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <u>0</u>	
	B	Number of fetal deaths / neonatal: (within seven days of birth) <u>0</u>	
	C	Number of maternal deaths: (please submit separate report) <u>0</u>	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
<i>N/A</i>				

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
<i>N/A</i>						

Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
<i>N/A</i>			
Total Number of Postpartum Transfers from all sheets (3-C)			<input checked="" type="checkbox"/>

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
<i>N/A</i>					
Total Newborn Transfers from all sheets(3-D)					<input checked="" type="checkbox"/>

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
<i>N/A</i>						
Total Number of Fetal Death/Stillborn (4-A)						<input checked="" type="checkbox"/>

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name:

Connie Mullen

Signature:

Connie Mullen

Date Signed:

07/05/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: JENNIFER JOSEPH License #: MW 53
 Practice Name: THE BIRTH PLACE
 Address: 213 S DILLARD ST, Suite #340
Winter Garden, FL 34787
 Phone Number: 407-656-6938 Email: jennie@thebirthplace.org

SECTION II: CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)		
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):				83		
	B	Total number of maternity clients you accepted for care in the reporting period:				83		
	C	Total number of deliveries you performed during reporting period:				63		
	D	Total number of licensed midwife students assigned to you during the reporting period:				0		
	E	How many delivered at: Home:	0	Birthing Ctr:	63	Hospital:	20	83
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	0	# of primary VBAC:	0	# of subsequent VBAC:	0	0
	H	Number of water births:				7		
	I	Number of mothers requiring sutures:				25		
3	A	Number of mothers transferred antepartum (for medical reasons):				20		
	B	Number of mothers transferred intrapartum:				9		
	C	Number of mothers transferred postpartum: (medical reasons)				2		
	D	Number of newborn transfers:				0		
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0		
	B	Number of fetal deaths / neonatal: (within 7 days of life)				0		
	C	Number of maternal deaths: (please submit separate report)				0		

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(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
12/13/17	HYPERTENSION		
02/23/18	RETAINED PLACENTA		
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: JENNIFER JOSEPH

Signature: 

Date: 7/17/18

3-A ANTEPARTUM TRANSFER (Medical Reason)

Date	Reason for Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome if Known (NSVD, VAC, Forceps, C/S)
7/7/2017	PATIENT CHOICE	Unknown	40	
7/22/2017	PATIENT CHOICE	Unknown	40	
7/19/2017	PATIENT CHOICE	Unknown	40	
8/7/2017	POST DATES	C SECTION	42	
9/13/2017	PATIENT CHOICE	Unknown	41	
9/19/2017	PATIENT CHOICE	Unknown	40	
9/19/2017	PATIENT CHOICE	Unknown	41	
10/18/2017	POST DATES BPP 6/8	Vaginal		
12/11/2017	PATIENT CHOICE	Unknown	40	
12/19/2017	HYPERTENSION PT. INDUCED	Unknown	37	
12/14/2017	PRETERM BIRTH	Unknown	36	
12/23/2017	BPP 6/8	Unknown	41	
12/24/2017	NO MIDWIFE	Unknown	40	
12/24/2017	PROM	Unknown	37	
1/11/2018	FTP	Unknown	39	
2/13/2018	FTP	Unknown	38	
2/13/2018	FTP	Unknown	41.4	
3/26/2018	HTN POSS PRE E	Unknown	40.2	
4/12/2018	FTP	Unknown	40.3	
6/14/2018	HYPERTENSION	Unknown	40.6	
Total Number of Intrapartum Transfers from all sheet (3-A):				20

I am employed by an OB-GYN physician to do prenatal & postpartum care only. I do NOT have my own practice and do not do births. All patients/clients I see are under the auspices of the physician.



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Yvonda L. Hedrick License #: MW560
 Practice Name: Crystal River Women's Health Center (Employer)
 Address: 6151 N. Suncoast Blvd.
Crystal River, FL 34428

Phone Number: (352) 794-0878 Email: midwifehedrick@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
E	How many delivered at: Home: <input type="checkbox"/> Birthing Ctr: <input type="checkbox"/> Hospital: <input checked="" type="checkbox"/>	
	F	Number of unplanned: Breech: <input type="checkbox"/> Twins / Multiples: <input type="checkbox"/>
	G	Number of planned VBAC: # of primary VBAC: <input type="checkbox"/> # of subsequent VBAC: <input type="checkbox"/>
H	Number of water births: <input type="checkbox"/>	
I	Number of mothers requiring sutures: <input type="checkbox"/>	
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
	N/A				

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	N/A	
Total Number of Maternal Deaths (4-C)		

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Yvonda L. Hedrick
Signature: *Y Hedrick*
Date Signed: 7/10/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

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June 30th 2017
to July 1st 2018

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jennifer Mitchell License #: MW 63
 Practice Name: Jennifer Mitchell L.M.
 Address: 6213 Country Fair Circle
Boynton Beach FL 33437
 Phone Number: 954-260-5730 Email: Awomansway1748@aatt.net

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					12	
	B	Total number of maternity clients you accepted for care in the reporting period:					12	
	C	Total number of deliveries you performed during reporting period:					5	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	5	Birthing Ctr:	0	Hospital:	4	9
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:			0
	H	Number of water births:					0	
	I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					4	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)

NA

Total Number of Antepartum Transfers from all sheet (3-A) 0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

2018

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
1.26	Failure to progress	C-S	None	8 ^{lbs}	No	No
2.16	SROM at 35 wks	Vag	None	6 ^{lbs 6}	No	No
4.5	Failure to progress	C-S	None	7 ^{lbs 4}	No	No
5.03	Failure to progress	Vag	Given Epidural and allowed to progress	7 ^{lbs}	No	No

Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	<i>NA</i>
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Printed Name: JENNIFER MITCHELL

Signature: *J Mitchell*

Date Signed: 7.22.18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FIHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: NADINE GUTIERREZ License #: MW # 70
 Practice Name: _____
 Address: 7890 S.W. 98 Street.
MIAMI, FL 33156
 Phone Number: 305-299-8398 Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:	0
F	Number of unplanned:	Breech:		Twins / Multiples		0	
G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		0	
H	Number of water births:					0	
I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

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(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: NADINE GUTIERREZ
Signature: 
Date Signed: 12-17-2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

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Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Dawn Rogula License #: MW74
 Practice Name: Dawn Rogula, L.M.
 Address: 494118 5th Ave SW
Naples, FL 34116
 Phone Number: 239-601-4002 Email: marievya@naples.net

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					44	
	B	Total number of maternity clients you accepted for care in the reporting period:					30	
	C	Total number of deliveries you performed during reporting period:					29	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	29	Birthing Ctr:	<input type="checkbox"/>	Hospital:	<input type="checkbox"/>	<input type="checkbox"/>
	F	Number of unplanned: Breech:	<input type="checkbox"/>	Twins / Multiples	<input type="checkbox"/>			<input type="checkbox"/>
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	4	5	
	H	Number of water births:					14	
	I	Number of mothers requiring sutures:					<input type="checkbox"/>	
3	A	Number of mothers transferred antepartum (for medical reasons):					2	
	B	Number of mothers transferred intrapartum:					1	
	C	Number of mothers transferred postpartum: (medical reasons)					2	
	D	Number of newborn transfers:					<input type="checkbox"/>	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					<input type="checkbox"/>	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					<input type="checkbox"/>	
	C	Number of maternal deaths: (please submit separate report)					<input type="checkbox"/>	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
2-19-18	Retained Placenta	2	2 units blood / Good
5-25-18	Retained Placenta	same day	Good
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons):
List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7-21-17	Hyper tension pre-eclampsia	unplanned	39	NSVD
11-9-17	Prolonged ROM @ ctz	unplanned	38	NSVD

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NiCU? If yes, reason and # of days	Neonatal Death?
4-22-18	Mother wished epidural	NSVD	⊖	7 ¹⁰	No	⊖

Total Intrapartum Transfers from all sheets (3-B)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Dawn Rogula, L.M.

Signature: Dawn Rogula, L.M.

Date: 7-30-2018



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bln #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwifs Names: Rachel Brownstein Licsnee #: mw78
 Practice Name: _____
 Address: 3222 Taragrove Dr.
Tampa FL 33618
 Phone Number: 813-417-2278 Email: raebrow11@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for csre and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accpcted for care in the reporting period:					0
	C	Total number of deliverles you performed during reporting period:					0
	D	Total number of licensed midwife studsnts assigned to you during ths reporting period:					0
	E	How many delivrsd at: Home:	<input type="radio"/>	Birthng Ctr:	<input type="radio"/>	Hospital:	<input type="radio"/>
F	Number of unplanned: Breech:	<input type="radio"/>	Twine / Multiples	<input type="radio"/>			0
G	Numbsr of planned VBAC:	# of primary VBAC:	<input type="radio"/>	# of subsequent VBAC:	<input type="radio"/>		0
H	Number of water births:					0	
I	Number of mothers requiring sutures:					0	
3	A	Number of mothrs transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothrs transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetel deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of meternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live Infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Rachel Brownstein

Signature: 

Date Signed: 9/8/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jelena Kamelka License #: MW 81

Practice Name: _____

Address: 13559 24th N
Loxahatchee, FL 33470

Phone Number: 561-541-1280 Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
E	How many delivered at: Home:		0	Birthing Ctr:	0	Hospital:	0
	Number of unplanned: Breech:		0	Twins / Multiples	0		
G	Number of planned VBAC:		# of primary VBAC:	0	# of subsequent VBAC:	0	0
	H Number of water births:						0
I Number of mothers requiring sutures:						0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed 0

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)

Total Number of Antepartum Transfers from all sheet (3-A) 0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed. 0

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?

Total Intrapartum Transfers from all sheets (3-B) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.) 0

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.) 0

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only) 0

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant) 0

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT) 0

Number of Reports Attached		
Total Number of Maternal Deaths (4-C)		0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Jelena Kameka
Signature: *Jelena Kameka*
Date Signed: 8/29/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kevin Michelle Graf-Dixon License #: MW83

Practice Name: Heart 2 Heart Birth Center

Address: 1110 Lexington Green Lane
Sanford FL 32771

Phone Number: 407-322-9944 Email: michelle@h2hbirthcenter.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					16	
	B	Total number of maternity clients you accepted for care in the reporting period:					161	
	C	Total number of deliveries you performed during reporting period:					14	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	1	Birthing Ctr:	B	Hospital:	0	14
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		0	0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	0	0
	H	Number of water births:					4	
	I	Number of mothers requiring sutures:					4	
3	A	Number of mothers transferred antepartum (for medical reasons):					2	
	B	Number of mothers transferred intrapartum:					3	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					1	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
4/8/18	Pyleonephritis	planned	24	Vag
7/1/17	Preeclampsia	unplanned	37	Vag

Total Number of Antepartum Transfers from all sheet (3-A) **2**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7/31	Hypertension	C/S				N
8/18	Failure to progress	Vag C/S		7.4	NO	NO
4/22/18	Meconium, Pain Man.	Vag	mec aspiration	9.3	yes - 2 days	NO

Total Intrapartum Transfers from all sheets (3-B) **3**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	none		

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
6/3/18	Respiratory Distress	3430	/	1	Stabilized, released
			/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D) 1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kevin Michelle Graf-Dixon
 Signature: K. Michelle Graf Dixon
 Date Signed: 07/23/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Pamela D. Peach **License #:** 84
Practice Name: Woman's Ways
Address: 209 Cartier Ave. Melbourne, FL. 32901
Phone Number: 321-984-0553 **Email:** PamPeach_LM@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					11	
	B	Total number of maternity clients you accepted for care in the reporting period:					11	
	C	Total number of deliveries you performed during reporting period:					7	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
E	How many delivered at:	Home:	7	Birthing Ctr:	0	Hospital:	4	11
	F	Number of unplanned:	Breech:	0	Twins / Multiples:	0		0
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0	
	H	Number of water births:					6	
I	Number of mothers requiring sutures:					0		
	3	A	Number of mothers transferred antepartum (for medical reasons):					2
B		Number of mothers transferred intrapartum:					2	
C		Number of mothers transferred postpartum: (medical reasons)					0	
D		Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
9/21/17	SGA, and personal preference.	Planned	32	SVD
3/1/18	Cholestasis.	Planned	33	SVD

Total Number of Antepartum Transfers from all sheet (3-A) 2

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
10/16/17	Failure to progress.	SVD	None.	7 lbs.	No.	No.
8/18/17	Failure To Progress.	SVD	None.	7.14 lbs	No.	No.

Total Intrapartum Transfers from all sheets (3-B) 2

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Pamela D Peach

Signature: Pam Peach, LM

Date Signed: 7/31/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Sharon Schmidt License #: MW88
 Practice Name: Fruitful Vine Midwifery / UF North BC
 Address: 2221 University Blvd W
Jax, FL 32227
 Phone Number: (904) 855-4211 Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <u>27</u>
	B	Total number of maternity clients you accepted for care in the reporting period: <u>23</u>
	C	Total number of deliveries you performed during reporting period: <u>32</u>
	D	Total number of licensed midwife students assigned to you during the reporting period: <u>1</u>
E	How many delivered at: Home: <u>21</u> Birthing Ctr: <u>11</u> Hospital: <u>0</u>	
F	Number of unplanned: Breech: <u>1</u> Twins / Multiples: <u>0</u>	
G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u>	
H	Number of water births: <u>17</u>	
I	Number of mothers requiring sutures: <u>2</u>	
3	A	Number of mothers transferred antepartum (for medical reasons): <u>1</u>
	B	Number of mothers transferred intrapartum: <u>1</u>
	C	Number of mothers transferred postpartum: (medical reasons) <u>0</u>
	D	Number of newborn transfers: <u>0</u>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <u>0</u>
	B	Number of fetal deaths / neonatal: (within seven days of birth) <u>0</u>
	C	Number of maternal deaths: (please submit separate report) <u>0</u>

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
1/23/18	42 wk for IOL	Planned	42	C/S
6/19/17				

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7/28	Fatigue, Pain mgmt	✓	None	8#	No	No

Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	None		

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	None				

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	None					

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	None			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	None	
Total Number of Maternal Deaths (4-C)		

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Sharon Schmidt
Signature: 
Date Signed: 7/23/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Marcela Guyton License #: MW90
 Practice Name: Midwifery Care LLC
 Address: 9760 SW 13 Terrace
Miami, FL 33174
 Phone Number: (305) 220-1772 Email: midwiferycare1@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 133
	B	Total number of maternity clients you accepted for care in the reporting period: 109
	C	Total number of deliveries you performed during reporting period: 0
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: <input type="checkbox"/> Birthing Ctr: <input type="checkbox"/> Hospital: <input type="checkbox"/> 0
F	Number of unplanned: Breech: <input type="checkbox"/> Twins / Multiples: <input type="checkbox"/> 0	
G	Number of planned VBAC: # of primary VBAC: <input type="checkbox"/> # of subsequent VBAC: <input type="checkbox"/> 0	
H	Number of water births: 0	
I	Number of mothers requiring sutures: 0	
3	A	Number of mothers transferred antepartum (for medical reasons): 13
	B	Number of mothers transferred intrapartum: 0
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
3-27-18	IUGR	Unplanned	35	
4-26-18	Previous C/S (x4)	Planned	16 ¹³	
4-26-18	Abnormal GTT	Unplanned	27 ¹²	
6-11-18	Abnormal GTT	Unplanned	30 ¹⁵	
6-19-18	Breech	Unplanned	34 ¹²	
6-26-18	Abnormal GTT	Unplanned	27 ¹³	
11-2-17	IUGR	Unplanned	35	
8-31-17	U fibroids + HBsAg ⊕	Planned	13 ¹⁰	
1-2-18	Twins + Von Willebrand f.	Planned	22	
1-23-18	Abnormal GTT	Unplanned	30	
2-13-18	U. fibroids.	Planned	20 ¹⁶	
7-3-17	Abnormal GTT	Unplanned	20	
7-20-17	⊕ KPR / TPA	Unplanned	34 ¹⁵	
Total Number of Antepartum Transfers from all sheet (3-A)				13

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? if yes, reason and # of days	Neonatal Death?
/						

Total Intrapartum Transfers from all sheets (3-B) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Marcela Guyton
Signature: Marcela Guyton
Date Signed: July 14, 2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:

MQA.Midwifery@FLHhs.gov



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Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Marianne Power **License #:** MW92
Practice Name: Lakeland Midwifery Care
Address: 1923 S Florida Avenue, Lakeland, FL 33803
Phone Number: 863-683-4663 **Email:** lakelandmidwifery@gmail.com

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					64
	B	Total number of maternity clients you accepted for care in the reporting period:					64
	C	Total number of deliveries you performed during reporting period:					16
	D	Total number of licensed midwife students assigned to you during the reporting period:					5
E	How many delivered at: Home:	16	Birthing Ctr:		Hospital:	16	
F	Number of unplanned: Breech:		Twins / Multiples			0	
G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		0	
H	Number of water births:					6	
I	Number of mothers requiring sutures:					3	
3	A	Number of mothers transferred antepartum (for medical reasons):					9
	B	Number of mothers transferred intrapartum:					3
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/10/17	Postdates	P	40+5	NVD
7/24/17	Postdates	P	42	NVD
8/26/17	SAB	N/A	8	SAB
10/2/17	SAB	N/A	10	SAB
12/28/17	Complete Previa	P	28+5	C-Section
3/8/18	SAB	N/A	8	SAB
3/8/18	Preterm PROM	U	32+6	NVD
3/9/18	SAB	N/A	9+2	SAB
3/15/18	Preeclampsia	U	37+2	C-section

Total Number of Antepartum Transfers from all sheet (3-A) **9**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		Neonatal Death?
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	
1/25/18	Failure to progress	NVD	None	8 lbs 7 oz	No	No
2/28/18	Prolonged rupture	NVD	None	8 bs 9 oz	No	No
4/18/18	Client chose to go to hospital	NVD	None	8lbs 7 oz	No	No

Total Intrapartum Transfers from all sheets (3-B) **3**

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/10/17	Postdates	P	40+5	NVD
7/24/17	Postdates	P	42	NVD
8/26/17	SAB	N/A	8	SAB
10/2/17	SAB	N/A	10	SAB
12/28/17	Complete Previa	P	28+5	C-Section
3/8/18	SAB	N/A	8	SAB
3/8/18	Preterm PROM	U	32+6	NVD
3/9/18	SAB	N/A	9+2	SAB
3/15/18	Preeclampsia	U	37+2	C-section

Total Number of Antepartum Transfers from all sheet (3-A) **9**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		Neonatal Death?
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	
1/25/18	Failure tp progress	NVD	None	8 lbs 7oz	No	No
2/28/18	Prolonged rupture	NVD	None	8 bs 9 oz	No	No
4/18/18	Client chose to go to hospital	NVD	None	8lbs 7 oz	No	No

Total Intrapartum Transfers from all sheets (3-B) **3**

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Marianne Power
Signature: Marianne Power LM
Date Signed: 7/26/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Corina Fitch License #: 102
 Practice Name: Bellymama Midwifery
 Address: 47 NE 91 St
Miami FL 33138
 Phone Number: 305-308-5900 Email: corina@bellymamamidwifery.com

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <u>27</u>
	B	Total number of maternity clients you accepted for care in the reporting period: <u>26</u>
	C	Total number of deliveries you performed during reporting period: <u>22</u>
	D	Total number of licensed midwife students assigned to you during the reporting period: <u>0</u>
	E	How many delivered at: Home: <u>21</u> Birthing Ctr: <u>0</u> Hospital: <u>2</u> <u>22</u>
	F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>1</u> <u>1</u>
	G	Number of planned VBAC: # of primary VBAC: <u>1</u> # of subsequent VBAC: <u>2</u> <u>3</u>
	H	Number of water births: <u>17</u>
	I	Number of mothers requiring sutures: <u>2</u>
3	A	Number of mothers transferred antepartum (for medical reasons): <u>1</u>
	B	Number of mothers transferred intrapartum: <u>1</u>
	C	Number of mothers transferred postpartum: (medical reasons) <u>0</u>
	D	Number of newborn transfers: <u>1</u>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <u>0</u>
	B	Number of fetal deaths / neonatal: (within seven days of birth) <u>0</u>
	C	Number of maternal deaths: (please submit separate report) <u>0</u>

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
5/4/18	Bipolar disorder	Unplanned	32	unknown
1/19/18	Preferred hospital birth	Planned	38	C/S

Total Number of Antepartum Transfers from all sheet (3-A) **2**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
3/25/18	Failure to progress	C/S	None	8-4	No	No

Total Intrapartum Transfers from all sheets (3-B) **1**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
4/24/18	Retractions/Tachypnea	8-6	9/9	Yes/4	Discharged in good condition
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

Signature: _____

Date Signed: _____

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Cecilia "Betsy" Bilbao License #: MW107
 Practice Name: Birthguardian Maternity Care
 Address: 1771 NW 106 terr
Pembroke Pines FL 33026
 Phone Number: 305 586 5619 Email: btilbao@birthguardian.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					31	
	B	Total number of maternity clients you accepted for care in the reporting period:					31	
	C	Total number of deliveries you performed during reporting period:					22	
	D	Total number of licensed midwife students assigned to you during the reporting period:					3	
	E	How many delivered at: Home:	11	Birthing Ctr:	11	Hospital:	4	26
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:					11	
	I	Number of mothers requiring sutures:					8	
3	A	Number of mothers transferred antepartum (for medical reasons):					3	
	B	Number of mothers transferred intrapartum:					4	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					1	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
9/22/19	oligohydramnios	planned	27wga	C/S
5/21/18	NO FM; NO FHT	unplanned	32wga	MUSD in Hosp.
6/21/18	Gastroschisis	planned	20wga	unknown

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	Delivery Method	MOTHER	INFANT		
			Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
3/4/18	Failure to Progress	C/S	NONE	8lb10oz	NO	NO
3/5/18	Elevated BP	MUSD	NONE	10lb10oz	NO	NO
3/20/18	Prolonged ROM	MUSD	NONE	6lb7oz	NO	NO
5/5/18	Swollen Cervix ^{pain} lip	MUSD	NONE	7lb10oz	NO	NO

Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
7/6/16	Secondary Apnea ↳ Keenan Resuscitation	8lb 6oz	0/3	4-10	Healthy baby
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Cecilia "Betty" Bilba
Signature: Cecilia B Bilba
Date Signed: 7/30/18

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
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AUG 01 2018

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Rhonda Dexter License #: MW111
 Practice Name: Heart + Hands Homebirth Services
 Address: 14245 Ellerbee Street
Winter Garden, FL 34787
 Phone Number: 904-599-1903 Email: midwife111rd@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request, do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					1
	B	Total number of maternity clients you accepted for care in the reporting period:					1
	C	Total number of deliveries you performed during reporting period:					1
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
E	How many delivered at: Home:		Birthing Ctr:	Hospital:			1
	1	0	0	0			
F	Number of unplanned: Breech:		Twins / Multiples			0	
	0	0	0				
G	Number of planned VBAC: # of primary VBAC:		# of subsequent VBAC:			0	
	0	0	0				
H	Number of water births:					0	
I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):				0	
	B	Number of mothers transferred intrapartum:				0	
	C	Number of mothers transferred postpartum: (medical reasons)				0	
	D	Number of newborn transfers:				0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)				0	
	C	Number of maternal deaths: (please submit separate report)				0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Rhonda Dexter, LM
 Signature: 
 Date Signed: 7/19/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

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ANNUAL REPORT OF MIDWIFERY PRACTICE

AUG 22 2018

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

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SECTION I: PRACTICE INFORMATION

Midwife Name: Diane Albright, Lm License #: 113
 Practice Name: Tree of Life Birth & Gynecology
 Address: 1010 Arthur Ave
Orlando, FL 32804
 Phone Number: 407-257-6514 Email: midwifealbright@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2	
A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 59
B	Total number of maternity clients you accepted for care in the reporting period: 59
C	Total number of deliveries you performed during reporting period: 24
D	Total number of licensed midwife students assigned to you during the reporting period: 2
E	How many delivered at: Home: 14 Birthing Ctr: 10 Hospital: 0 24
F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0 0 0
G	Number of planned VBAC: # of primary VBAC: 1 # of subsequent VBAC: 1 2
H	Number of water births: 11
I	Number of mothers requiring sutures: 9
3	
A	Number of mothers transferred antepartum (for medical reasons): 5
B	Number of mothers transferred intrapartum: 6
C	Number of mothers transferred postpartum: (medical reasons) 1
D	Number of newborn transfers: 0
4	
A	Number of fetal deaths / stillborn: (midwife delivery only) 0
B	Number of fetal deaths / neonatal: (within seven days of birth) 0
C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
8/1/17	Hypertension	unplanned	34	unknown
9/15/17	TriBony '18	planned	20	unknown
12/27/17	Breech	planned	38	C/S
1/5/18	Oligohydramnios w/decels BPP6/10	unplanned	40	C/S
2/12/18	PPROM @ 35 wks	unplanned	35	spont vag del.

Total Number of Antepartum Transfers from all sheet (3-A) **5**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7/18/17	meconium, thick	vag	None	8#2	No	No
10/2/17	Breech	C/S	None	7#2	No	No
1/5/18	PPROM - FTP	vag		8#4	No	No
3/2/18	FHT Decels	C/S	None	7#6	No	No
8/20/17	BREECH	C/S	None	7#6	No	No
3/15/18	FTP p complete dsl.	vag	None	7#13	No	No

Total Intrapartum Transfers from all sheets (3-B) **6**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
11/4/17	retained placenta	1	manual removed in dg/good condition

Total Number of Postpartum Transfers from all sheets (3-C) 1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Diane Albright, Lm
 Signature: *Diane Albright, Lm*
 Date Signed: 8/22/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bln #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Karen Bove, LM License #: MW115
 Practice Name: Karen Bove, LM
 Address: 423 Soft Shadow Lane
DeBary, FL 32713
 Phone Number: 407-493-3062 Email: karen@floridahomebirth.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					20	
	B	Total number of maternity clients you accepted for care in the reporting period:					20	
	C	Total number of deliveries you performed during reporting period:					14	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	14	Birthing Ctr:	0	Hospital:	0	14
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	1		1
	H	Number of water births:					4	
	I	Number of mothers requiring sutures:					3	
3	A	Number of mothers transferred antepartum (for medical reasons):					2	
	B	Number of mothers transferred intrapartum:					2	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
12/31	GDM	Y	40	NSVD
7/26	Post Dates	Y	42	NSVD
Total Number of Antepartum Transfers from all sheet (3-A)				2

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
04/15	PPROM	NSVD	None	7-6	No	No
6/24	Pain Relief/Dysfunctional Labor	NSVD	None	7-6	No	No
Total Intrapartum Transfers from all sheets (3-B)						2

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

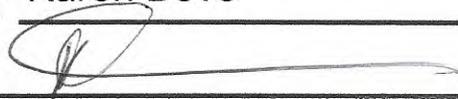
(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Karen Bove

Signature: _____



Date Signed: 07/31/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION 1: PRACTICE INFORMATION

Midwife Name: Karen Kennedy LM License #: MW116
 Practice Name: Agape Midwifery Services
 Address: 1346 Mason Ave
Daytona Beach FL 32117
 Phone Number: 386 258-5400 Email: info@agapemidwiferyservices.org

SECTION 2: CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the reporting year only)

Section number		Total(s)		
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):	56	
	B	Total number of maternity clients you accepted for care in the reporting period:	47	
	C	Total number of deliveries you performed during reporting period:	27	
	D	Total number of licensed midwife students assigned to you during the reporting period:	3	
	E	How many delivered at: Home: <u>10</u> Birthing Ctr: <u>17</u> Hospital: <u>0</u>		
	F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>		
	G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC:	0	
	H	Number of water births:	7	
	I	Number of mothers requiring sutures:	9	
	3	A	Number of mothers transferred antepartum (for medical reasons):	15
		B	Number of mothers transferred intrapartum:	5
C		Number of mothers transferred postpartum: (medical reasons)	0	
D		Number of newborn transfers:	1	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)	0	
	C	Number of maternal deaths: (please submit separate report)	0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
4/17/18	increased Resperations	10/7	9/10	yes/4 days	great
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Cause of Death	Site of Death	Birth Weight	Age at Death	
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached		
Total Number of Maternal Deaths (4-C)		0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Karen Kennedy LM
Signature: Karen Kennedy LM
Date: 7/23/18



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bln #C-06
 Tallahassee, FL 32399-3268
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Carlene CANADY License #: MDW 117
 Practice Name: _____
 Address: _____

Phone Number: 786 284-2304 Email: ccanady@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Includes data for the report year only)

Section number					Total(s)	
2	A	Total number of Initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:			0	
	B	Total number of maternity clients you accepted for care in the reporting period:			0	
	C	Total number of deliveries you performed during reporting period:			0	
	D	Total number of licensed midwife students assigned to you during the reporting period:			0	
	E	How many delivered at: Home:	<input checked="" type="checkbox"/>	Birthing Ctr:	<input checked="" type="checkbox"/>	Hospital: 0
F	Number of unplanned: Breech:		Twins / Multiple:			0
G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		0
H	Number of water births:				0	
I	Number of mothers requiring sutures:				0	
3	A	Number of mothers transferred antepartum (for medical reasons):			0	
	B	Number of mothers transferred intrapartum:			0	
	C	Number of mothers transferred postpartum: (medical reasons)			0	
	D	Number of newborn transfers:			0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)			0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)			0	
	C	Number of maternal deaths: (please submit separate report)			0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, If Known (NSVD, VAC, Forceps, C/S)

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?

Total Intrapartum Transfers from all sheets (3-B)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Catherine CANADY

Signature: *Catherine Canady*

Date Signed: 8/29/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Mary Harris License #: MW 119
 Practice Name: A Loving Start
 Address: 3001 W. Hallandale Bch Blvd #200
Hallandale, FL 33009
 Phone Number: 305-215-8763 Email: meharris5@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 59
	B	Total number of maternity clients you accepted for care in the reporting period: 55
	C	Total number of deliveries you performed during reporting period: 42
	D	Total number of licensed midwife students assigned to you during the reporting period: 1
	E	How many delivered at: Home: 37 Birthing Ctr: 5 Hospital: 4
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0
	G	Number of planned VBAC: 3 # of primary VBAC: 3 # of subsequent VBAC: 0
	H	Number of water births: 9
	I	Number of mothers requiring sutures: 5
3	A	Number of mothers transferred antepartum (for medical reasons): 2
	B	Number of mothers transferred intrapartum: 4
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	NIA		

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
	NIA				

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NIA					

Total Number of Fetal Death/Stillborn (4-A)

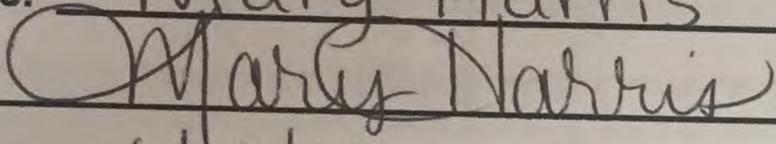
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NIA			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	NIA	
Total Number of Maternal Deaths (4-C)		0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Mary Harris
 Signature: 
 Date Signed: 6/19/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: DEBORAH DiGiacomo License #: MW 120
 Practice Name: _____
 Address: 3001 W. HALLANDALE BCH BLVD #200
HALLANDALE, FL 33009
 Phone Number: 954-494-8489 Email: SHAMAN BEN@AOL.COM
 Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
E	How many delivered at: Home:		Birthing Ctr:		Hospital:	0	
F	Number of unplanned:	Breach:	Twins / Multiples			0	
G	Number of planned VBAC:	# of primary VBAC:	# of subsequent VBAC:			0	
H	Number of water births:					0	
I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) /S

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) /S

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) /S

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C) 0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: DEBORAH DiGiAcomo @AOL.COM
 Signature: Deborah DiGiAcomo
 Date Signed: 7/20/18
SHAMANBFN@AOL.COM

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Heidi Dahlborg **License #:** MW123
Practice Name: Not practicing
Address: Sweden

Phone Number: 941726 8203 **Email:** midwife@heididahlborg.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:		0
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	Not applicable			
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
	Not applicable					
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	Not applicable		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	Not applicable		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	Not applicable					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	Not applicable			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Heidi DAhlborg

Signature: H e i d i D a h l b o r g

Date Signed: July 31 2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jill Welch License #: MW 134
 Practice Name: Blessed Be Midwifery
 Address: PO Box 3422 Tallahassee, FL 32315
 Phone Number: 850-443-2953 Email: jillynewilly@netscape.net

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):	8
	B Total number of maternity clients you accepted for care in the reporting period:	8
	C Total number of deliveries you performed during reporting period:	7
	D Total number of licensed midwife students assigned to you during the reporting period:	0
	E How many delivered at: Home: <u>2</u> Birthing Ctr: <u>5</u> Hospital:	7
	F Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>	0
	G Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u>	0
	H Number of water births:	4
	I Number of mothers requiring sutures:	1
3	A Number of mothers transferred antepartum (for medical reasons):	0
	B Number of mothers transferred intrapartum:	0
	C Number of mothers transferred postpartum: (medical reasons)	0
	D Number of newborn transfers:	0
4	A Number of fetal deaths / stillborn: (midwife delivery only)	0

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Jill Welch

Signature: Jill Welch

Date Signed: 7/23/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Quetzal Currie License #: 137
 Practice Name: _____
 Address: 40 Harrison st #316
Ny Ny 10013
 Phone Number: 646-541-3990 Email: Doulanyc@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____
	F	Number of unplanned: Breech: _____ Twins / Multiples _____
	G	Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____
3	H	Number of water births:
	I	Number of mothers requiring sutures:
	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
4	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Quetzal Currie
Signature: Quetzal Currie
Date Signed: 8.30.18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Dawn Meier License #: MW139
 Practice Name: Family Birth Center of Naples
 Address: 2930 Immokalee Rd, Ste 2
Naples, FL 34110
 Phone Number: 239 554 0400 Email: fbcNaples@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number	Total(s)
2	
A	Total number of initial OB client visits. include both clients accepted for care and those clients initially seen but not accepted into your care: 113
B	Total number of maternity clients you accepted for care in the reporting period: 113
C	Total number of deliveries you performed during reporting period: 60
D	Total number of licensed midwife students assigned to you during the reporting period: 0
E	How many delivered at: Home: <input checked="" type="radio"/> Birthing Ctr: 60 Hospital: <input type="radio"/>
F	Number of unplanned: Breech: <input type="radio"/> Twins / Multiples: <input type="radio"/>
G	Number of planned VBAC: # of primary VBAC: <input type="radio"/> # of subsequent VBAC: <input type="radio"/>
H	Number of water births: 26
I	Number of mothers requiring sutures: 3
3	
A	Number of mothers transferred antepartum (for medical reasons): 22
B	Number of mothers transferred intrapartum: 8
C	Number of mothers transferred postpartum: (medical reasons) 0
D	Number of newborn transfers: 1
4	
A	Number of fetal deaths / stillborn: (midwife delivery only) 0
B	Number of fetal deaths / neonatal: (within seven days of birth) 0
C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
8/02	breech	P	41	C/S
8/09	Post dates	P	41	C/S
8/27	Precipitous Homebirth	Unplanned	35	NSVD
10/18	breech	P	37	C/S
11/28	SAB	P	8	—
11/29	Pre eclampsia	P	33	UNK
12/01	SAB	P	12	—
12/20	Uterine Mass	P	19	UNK
02/02	breech	P	38	C/S
02/04	PTL	P	35	NSVD
02/07	twins	P	11	UNK
02/09	Pre eclampsia	P	38	C/S
02/05	Precipitous homebirth	Unplanned	40	NSVD
03/02	Persistent UTI	P	17	UNK
03/12	Hyper tension, Kidney stones	P	31	UNK
03/14	PTL	P	36	NSVD
03/15	PTL	P	25	NSVD
04/22	Pre eclampsia	P	33	NSVD
05/30	Diabetes	P	23	UNK
02/02	Varicosities	P	17	UNK
06/26	Post dates, Low AFL	P	40	NSVD
02/09	Precipitous homebirth	Unplanned	40	NSVD

Total Number of Antepartum transfers (3-A)

22

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

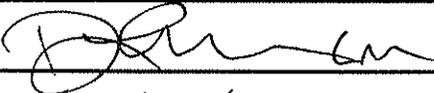
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Dawn Meyer
Signature: 
Date Signed: 07/11/18

Mall completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bln #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
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 AUG 01 2018
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: SARAH ANN BALDWIN License #: 140
 Practice Name: BIRTH + WELLNESS CENTER
 Address: 607 E. UNIVERSITY AVE
GAINESVILLE FL 32061
 Phone Number: 386 454-4760 Email: SARAHBALDWIN14@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2 A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 5
B	Total number of maternity clients you accepted for care in the reporting period: 5
C	Total number of deliveries you performed during reporting period: 5
D	Total number of licensed midwife students assigned to you during the reporting period: 1
E	How many delivered at: Home: 0 Birthing Ctr: 5 Hospital: 0 5
F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0
G	Number of planned VBAC: 0 # of primary VBAC: 0 # of subsequent VBAC: 0 0
H	Number of water births: 5
I	Number of mothers requiring sutures: 0
3 A	Number of mothers transferred antepartum (for medical reasons): 0
B	Number of mothers transferred intrapartum: 0
C	Number of mothers transferred postpartum: (medical reasons) 0
D	Number of newborn transfers: 0
4 A	Number of fetal deaths / stillborn: (midwife delivery only) 0
B	Number of fetal deaths / neonatal: (within seven days of birth) 0
C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C)

0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A				

Total Newborn Transfers from all sheets(3-D)

0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	XI / A					

Total Number of Fetal Death/Stillborn (4-A)

0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: SARAH ANN BALDWIN
Signature: Sarah A. Baldwin
Date Signed: 7/25/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Shesha Simmons Watson License #: MW 141
 Practice Name: Spirit of Life Midwifery
 Address: 9745 SW 1461 Street Miami FL 33157

Phone Number: 786 287-0484 Email: miamimidwife@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	July 1, 2017 ~ June 30, 2018						Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					51	
	B	Total number of maternity clients you accepted for care in the reporting period:					51	
	C	Total number of deliveries you performed during reporting period:					29	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	29	Birthing Ctr:	0	Hospital:	0	29
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	1		2
	H	Number of water births:					22	
	I	Number of mothers requiring sutures:					1	
3	A	Number of mothers transferred antepartum (for medical reasons):					4	
	B	Number of mothers transferred intrapartum:					4	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
10/3/17	cholestasis	planned	37	NSVD
12/28/17	low amniotic fluid	unplanned	41	c-section
2/2/18	placenta previa	planned	39	c-section
5/3/18	placenta previa	planned	38	c-section

Total Number of Antepartum Transfers from all sheet (3-A) **4**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	Delivery Method	MOTHER		INFANT	
			Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
6/25/17	failure to progress	NSVD	NO	9/16 402	NO	
9/28/17	failure to progress	C/S	NO	7/14	NO	
8/10/18	PROM - failure to progress	NSVD	NO	8/0	NO	
9/25/18	failure to progress	NSVD	NO	9/0	NO	

Total Intrapartum Transfers from all sheets (3-B) **4**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

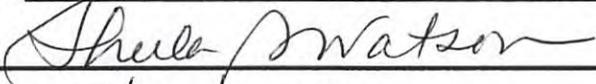
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Sheila Simms Watson, LM, CM, UPH
Signature: 
Date Signed: 7/31/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Anne Hirsch **License #:** MW195
Practice Name: Rosemary Birthing Home
Address: 800 Central Ave. Sarasota, Florida 34236
Phone Number: 941-330-9966 **Email:** anne@rosemarybirthing.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					51	
	B	Total number of maternity clients you accepted for care in the reporting period:					51	
	C	Total number of deliveries you performed during reporting period:					34	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	14	Birthing Ctr:	20	Hospital:	0	34
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	0	1	
	H	Number of water births:					18	
	I	Number of mothers requiring sutures:					12	
3	A	Number of mothers transferred antepartum (for medical reasons):					5	
	B	Number of mothers transferred intrapartum:					7	
	C	Number of mothers transferred postpartum: (medical reasons)					2	
	D	Number of newborn transfers:					2	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
11/28/17	Elevated BP, +Protein, R/O PreEclampsia	Unplanned	38.1	NSVD
9/4/17	Suspected cholestasis	Unplanned	39.3	NSVD 2ND DEGREE LAC, EPIDURAL
9/29/17	Elevated BP	Unplanned	37.5	NSVD PreEclampsiaDX at hospital
12/21/17	Breech Presentation	Planned	37.5	C/S
3/29/18	S<D	Unplanned	40	C/S 4LB9OZ Failed induction

Total Number of Antepartum Transfers from all sheet (3-A) **5**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
6/21/18	FTP 1st stage PRIMIP	NSVD	2 days in hospital	3997	No, 0	No
7/13/17	PROM, FTP 1ST stage, primip	NSVD	Episiotomy, vacuum extraction	3231.8	No, 0	No
7/27/17	PROM >18 hrs without established labor pattern	NSVD	Episiotomy	3373.5	No, 0	No
10/28/17	Fetal tachycardia Primip	C/S	2 days in hospital	Unknown	No, 0	No
11/19/17	FTP 1st stage PRIMIP	NSVD	Manual removal of placenta, blood transfusion	Unknown	No, 0	No
12/20/17	FTP 1st stage PRIMIP	C/S	2 days in hospital	3799	No, 0	No
10/28/17	FTP 1st stage, PROM>12 hrs Primip	C/S	GBS Neonatal Pneumonia	4110.6	Yes, 7	No

Total Intrapartum Transfers from all sheets (3-B) **7**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
5/24/18	4th degree laceration repair	<1	Laceration repaired DC to home
9/13/17	Hemorrhage, 3rd degree laceration	1	General anesthesia, repair of cervical and vaginal laceration
Total Number of Postpartum Transfers from all sheets (3-C)			2

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
2/19/18	Intermittent tachypne	3657	8,9	Yes, 3	Eval revealed congenital/structural throat anomaly
1/23/18	Thick mec, dusky appearance	3374	7,7	No	Eval in ER all WNL signed out AMA same day
Total Newborn Transfers from all sheets(3-D)					2

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Anne Hirsch

Signature: *Anne Hirsch*

Date Signed: 7/16/18

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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OSTEOPATHIC UNIT

JUL 13 2018

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31. RECEIVED

SECTION I: PRACTICE INFORMATION

Midwife Name: Rebecca Finklea, CPM, LM **License #:** MW 144
Practice Name: Precious Blessings Midwife Care, In Due Season Pregnancy Wellness & Birth Center, Sweet Child o Mine, LLC
Address: 3102 Gloria Avenue, Plant City, Florida 33563-2801
Phone Number: 813/451-4093 **Email:** precblessmw@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					56
	B	Total number of maternity clients you accepted for care in the reporting period:					56
	C	Total number of deliveries you performed during reporting period:					59
	D	Total number of licensed midwife students assigned to you during the reporting period:					2
	E	How many delivered at: Home:	23	Birthing Ctr:	36	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	1	
	H	Number of water births:					33
	I	Number of mothers requiring sutures:					15
3	A	Number of mothers transferred antepartum (for medical reasons):					23
	B	Number of mothers transferred intrapartum:					87
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					3
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					X 0
	C	Number of maternal deaths: (please submit separate report)					0

MW/44

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
2-5-18	Respiratory distress	7#7oz	7/9	Yes, 2 weeks	Diaphragmatic hernia, repaired, healthy
4-19-18	Respiratory Distress	9#10oz	3/6/7	yes, 2 days	Monitoring, labs, healthy
5/20/18	Respiratory distress	8#6oz	9/9	No	TTN, observe, d/c home prior to 24 hrs
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

MW144

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Rebecca Finklea, CPM, LM

Signature: 

Date Signed: 7/10/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-08
 Tallahassee, FL 32399-3256
 MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Erika D. Lampkin - Piagetti License #: MW146

Practice Name: _____

Address: 978 79th Terrace
Miami Beach, FL 33141

Phone Number: 305 432 5212 Email: tutti513@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <input type="text" value="0"/>
	B	Total number of maternity clients you accepted for care in the reporting period: <input type="text" value="0"/>
	C	Total number of deliveries you performed during reporting period: <input type="text" value="0"/>
	D	Total number of licensed midwife students assigned to you during the reporting period: <input type="text" value="0"/>
	E	How many delivered at: Home: <input type="text" value="0"/> Birthing Ctr: <input type="text" value="0"/> Hospital: <input type="text" value="0"/>
F	Number of unplanned: Breech: <input type="text" value="0"/> Twins / Multiples: <input type="text" value="0"/>	
G	Number of planned VBAC: <input type="text" value="0"/> # of primary VBAC: <input type="text" value="0"/> # of subsequent VBAC: <input type="text" value="0"/>	
H	Number of water births: <input type="text" value="0"/>	
I	Number of mothers requiring sutures: <input type="text" value="0"/>	
3	A	Number of mothers transferred antepartum (for medical reasons): <input type="text" value="0"/>
	B	Number of mothers transferred intrapartum: <input type="text" value="0"/>
	C	Number of mothers transferred postpartum: (medical reasons) <input type="text" value="0"/>
	D	Number of newborn transfers: <input type="text" value="0"/>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <input type="text" value="0"/>
	B	Number of fetal deaths / neonatal: (within seven days of birth) <input type="text" value="0"/>
	C	Number of maternal deaths: (please submit separate report) <input type="text" value="0"/>



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
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 4052 Bald Cypress Way, Bin #C-06
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JUL 30 2018

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

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SECTION I: PRACTICE INFORMATION

Midwife Name: DONNA S. Rarey License #: MW147
 Practice Name: DONNA Rarey
 Address: 573 SR 26
Melrose, FL 32666
 Phone Number: 352-281-2297 Email: midwifecarey@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

I did not see clients this period

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	0
	B	Total number of maternity clients you accepted for care in the reporting period:	0
	C	Total number of deliveries you performed during reporting period:	0
	D	Total number of licensed midwife students assigned to you during the reporting period:	0
	E	How many delivered at: Home: 0 Birthing Ctr: 0 Hospital: 0	0
F	Number of unplanned: Breech: 0 Twins / Multiples: 0	0	
G	Number of planned VBAC: # of primary VBAC: # of subsequent VBAC:	0	
H	Number of water births:	0	
I	Number of mothers requiring sutures:	0	
3	A	Number of mothers transferred antepartum (for medical reasons):	0
	B	Number of mothers transferred intrapartum:	0
	C	Number of mothers transferred postpartum: (medical reasons)	0
	D	Number of newborn transfers:	0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	0
	B	Number of fetal deaths / neonatal: (within seven days of birth)	0
	C	Number of maternal deaths: (please submit separate report)	0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Donna Susan Rarey
 Signature: Donna A Rarey, LM, CN
 Date Signed: 7/24/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
 Council of Licensed Midwifery
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Tammy Dieffenbach **License #:** MW152
Practice Name: ABUNDANT LIFE BIRTH CENTER, LLC
Address: 611 SW Federal Hwy., STE M, Stuart Florida 34994
Phone Number: 772-200-4277 **Email:** tammy@thealbc.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					10
	B	Total number of maternity clients you accepted for care in the reporting period:					10
	C	Total number of deliveries you performed during reporting period:					7
	D	Total number of licensed midwife students assigned to you during the reporting period:					2
	E	How many delivered at: Home:	5	Birthing Ctr:	2	Hospital:	0
F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	0	
H	Number of water births:					2	
I	Number of mothers requiring sutures:					2	
3	A	Number of mothers transferred antepartum (for medical reasons):					1
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

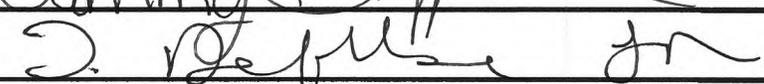
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Tammy Dieffenbach, um
Signature: 
Date Signed: 7-24-17

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Christina Holmes License #: 154
 Practice Name: Birthways Midwifery Care Inc
 Address: 4222 McIntosh Lane
Sarasota FL 34232
 Phone Number: 941 386 2229 Email: Christina@BirthwaysFamily.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:				81
	B	Total number of maternity clients you accepted for care in the reporting period:				81
	C	Total number of deliveries you performed during reporting period:				12
	D	Total number of licensed midwife students assigned to you during the reporting period:				3
	E	How many delivered at: Home:	2	Birthing Ctr:	10	Hospital:
F	Number of unplanned: Breech:	0	Twins / Multiples	0		
G	Number of planned VBAC:	0	# of primary VBAC:	0	# of subsequent VBAC:	0
H	Number of water births:				3	
I	Number of mothers requiring sutures:				3	
3	A	Number of mothers transferred antepartum (for medical reasons):				15
	B	Number of mothers transferred intrapartum:				3
	C	Number of mothers transferred postpartum: (medical reasons)				1
	D	Number of newborn transfers:				1
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0
	B	Number of fetal deaths / neonatal: (within seven days of birth)				0
	C	Number of maternal deaths: (please submit separate report)				0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/21/17	pre-term labor	u	35	NSVB
8/9/17	postdate induction / low AFI	u	41	NSVB
8/10/17	Postdate induction	u	41	NSVB
8/28/17	Breech	u	38.4	C/S
10/10/17	congenital defect diagnosed	u	19	C/S
10/23/17	multiple gestation	u	15	Unknown
11/8/17	Pre-eclampsia	u	35	C/S
11/10/17	Pre-eclampsia	u	38.3	NSVB
12/20/17	Postdate induction	u	42	NSVB
1/3/18	Abnormal pain	u	39	NSVB
1/8/18	postdate, low AFI induction	u	41	NSVB
Total Number of Antepartum Transfers from all sheet (3-A)				15

* See attached sheet

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7/10/17	Pain management	NSVB	∅	7.12	∅	∅
4/21/18	prolonged labor	C/S	∅	8.5	∅	∅
4/9/18	breech	C/S	∅	7.11	∅	∅
Total Intrapartum Transfers from all sheets (3-B)						3

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
8/22/17	transfer with baby	1	Stable
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
8/22/17	eval after shoulder dystocia	10.7	3/9	0	no complications
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

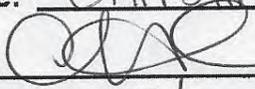
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Christina Holmes
Signature: 
Date Signed: 8/28/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

Date	Reason for Transfer	Planned/ unplanned	WGA	Delivery outcome
3/24/18	Hx of Shoulder Dystocia	Planned	41	NSVB
5/21/18	Hx of retained placenta with PPH	planned	40.4	NSVB
10/19/17	Multiple gestation	Unplanned	12	unknown
7/28/17	based on hx	Planned	21	unknown

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Barbara Blot License #: MW 158
 Practice Name: Natural Birth Choices
 Address: 11600 NE 8th Avenue
Miami, FL 33162
 Phone Number: 786-440-7546 Email: info@naturalbirthchoices.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number			Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):	29
	B	Total number of maternity clients you accepted for care in the reporting period:	28
	C	Total number of deliveries you performed during reporting period:	24
	D	Total number of licensed midwife students assigned to you during the reporting period:	1
	E	How many delivered at: Home: <u>24</u> Birthing Ctr: <u>0</u> Hospital: <u>0</u>	24
	F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>	0
	G	Number of planned VBAC: <u>2</u> # of primary VBAC: <u>1</u> # of subsequent VBAC: <u>1</u>	2
	H	Number of water births:	15
	I	Number of mothers requiring sutures:	6
3	A	Number of mothers transferred antepartum (for medical reasons):	2
	B	Number of mothers transferred intrapartum:	1
	C	Number of mothers transferred postpartum: (medical reasons)	0
	D	Number of newborn transfers:	1
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	0
	B	Number of fetal deaths / neonatal: (within 7 days of life)	0
	C	Number of maternal deaths: (please submit separate report)	0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)			
Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)					
Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
2/24/18	Further evaluation after resuscitation	7lb 4oz	4 7	No	Normal recovery
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS						
(4-A) STILLBIRTH (midwife delivered only)						
Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

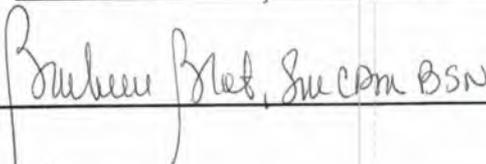
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Barbara Blot, LM CPM BSN

Signature: 

Date: 7/30/18



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32309-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Renee Clawson Lucien License #: mw1161
 Practice Name: not practicing
 Address: 4345 Honey Vista Cir.
Tampa, FL 33624
 Phone Number: 813 609 7190 Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number					Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:				0
	B	Total number of maternity clients you accepted for care in the reporting period:				
	C	Total number of deliveries you performed during reporting period:				
	D	Total number of licensed midwife students assigned to you during the reporting period:				
	E	How many delivered at: Home:	Birthing Ctr:	Hospital:		
	F	Number of unplanned: Breech:	Twins / Multiples			
	G	Number of planned VBAC:	# of primary VBAC:	# of subsequent VBAC:		
	H	Number of water births:				
	I	Number of mothers requiring sutures:				
3	A	Number of mothers transferred antepartum (for medical reasons):				
	B	Number of mothers transferred intrapartum:				
	C	Number of mothers transferred postpartum: (medical reasons)				
	D	Number of newborn transfers:				
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				
	B	Number of fetal deaths / neonatal: (within seven days of birth)				
	C	Number of maternal deaths: (please submit separate report)				0

not practicing

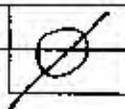
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
<i>N/A Not practicing</i>				
				Total Number of Fetal/Neonatal Deaths (4-B)

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)



I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name:

Renee C. Lucien

Signature:

Date Signed:

7/22/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4062 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Miriam M Maldonado License #: MW 165
 Practice Name: Childbirth Option-Miami
 Address: Miami FL 33255
Miami FL 33255
 Phone Number: (786) 234-9056 Email: mmmidwife@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					40	
	B	Total number of maternity clients you accepted for care in the reporting period:					40	
	C	Total number of deliveries you performed during reporting period:					16	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	16	Birthing Ctr:	0	Hospital:	0	16
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	0		1
	H	Number of water births:					13	
	i	Number of mothers requiring sutures:					2	
3	A	Number of mothers transferred antepartum (for medical reasons):					4	
	B	Number of mothers transferred Intrapartum:					2	
	C	Number of mothers transferred postpartum: (medical reasons)					1	
	D	Number of newborn transfers:					1	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
10/01/17	Retained Placenta	4	Good Recovery
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
02/18/18	Jaundice	6pd 8oz	9 / 10	Yes, 5	Good recovery
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached		
Total Number of Maternal Deaths (4-C)		0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Miriam M Maldonado

Signature: _____

Date Signed: 07/29/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jessica Stevenson **License #:** MW171
Practice Name: MIDWIVES COOPERATIVE LLC
Address: 2602 NW 6th Street, Ste B, Gainesville, FL 32609
Phone Number: 352 377 3879 **Email:** midwivescooperative@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					18
	B	Total number of maternity clients you accepted for care in the reporting period:					18
	C	Total number of deliveries you performed during reporting period:					11
	D	Total number of licensed midwife students assigned to you during the reporting period:					2
	E	How many delivered at: Home:	11	Birthing Ctr:	0	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	
	H	Number of water births:					3
	I	Number of mothers requiring sutures:					3
3	A	Number of mothers transferred antepartum (for medical reasons):					3
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	NONE		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	0		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NONE					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

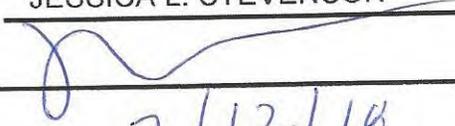
Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NONE			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: JESSICA L. STEVENSON

Signature: 

Date Signed: 7/12/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ License #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____
	F	Number of unplanned: Breech: _____ Twins / Multiples: _____
	G	Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____
	H	Number of water births:
	I	Number of mothers requiring sutures:
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

Signature: _____

Date Signed: _____

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

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JUL 27 2018

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

RECEIVED

SECTION I: PRACTICE INFORMATION

Midwife Name: Melissa Conard-Monow License #: 175

Practice Name: Celebrate Birth

Address: 1525 Edgewater Beach Dr.
Lakeland, FL 33805

Phone Number: 803-680-2229 Email: celebratebirth@live.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 40
	B	Total number of maternity clients you accepted for care in the reporting period: 135
	C	Total number of deliveries you performed during reporting period: 33
	D	Total number of licensed midwife students assigned to you during the reporting period: 2
	E	How many delivered at: Home: 4 Birthing Ctr: 29 Hospital: 0 33
F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0	
G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0 0	
H	Number of water births: 4	
I	Number of mothers requiring sutures: 9	
3	A	Number of mothers transferred antepartum (for medical reasons): 3
	B	Number of mothers transferred intrapartum: 8
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
9/16	IUGR	Unplanned	38	NSVD
11/19	Cholestasis	Unplanned	37	NSVD
3/23	LGA	Unplanned	41	C/S

Total Number of Antepartum Transfers from all sheet (3-A) **3**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
9/10	FTP w/Rom	NSVD	∅	7#6	N/A	∅
11/17	FTP w/Rom	C/S	∅	8#10	N/A	∅
12/24	FTP w/Rom	C/S	∅		N/A	∅
12/29	Fetal Distress	C/S	∅	9#1	yes, 7 days	∅
2/8	FTP w/Rom	NSVD	∅		N/A	∅
2/13	FTP	NSVD	∅		N/A	∅
2/21	Thick meconium	NSVD	∅		N/A	∅
4/13	FTP w/Rom	NSVD	∅		N/A	∅

Total Intrapartum Transfers from all sheets (3-B) **8**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Melissa Concord-Monroe, MW 175
Signature: Melissa R. Concord-Monroe, MW, RD, FBCRC
Date Signed: 07/20/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
 Council of Licensed Midwifery
 400 West Cypress Way, Box 9048
 Tallahassee, FL 32309-3248
 www.floridamidwifery.com

ANNUAL REPORT OF MIDWIFERY PRACTICE

Please use this form to report your 2014 midwifery practice for the reporting period from July 1, 2014 to June 30, 2015.

SECTION 1 PRACTICE INFORMATION

Practice Name: Probe White License # 100117
 Practice Address: Probe White, 100117, 100117, 100117
 Address: 100117, 100117, 100117

Please provide a copy of this report to the Council of Licensed Midwifery, 400 West Cypress Way, Tallahassee, FL 32309-3248.

SECTION 2 CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Question	Answer	Total
1. Total number of initial OB client visits. Includes both clients accepted for care and those clients initially seen but not accepted into your care.		0
2. Total number of maternity clients you accepted for care in the reporting period.		0
3. Total number of deliveries you performed during reporting period.		0
4. Total number of licensed midwife students assigned to you during the reporting period.		0
5. How many delivered as follows: <input type="checkbox"/> Spontaneous, <input type="checkbox"/> Induced, <input checked="" type="checkbox"/> Cesarean		
6. Number of unplanned: <input type="checkbox"/> Elective, <input type="checkbox"/> Trauma, <input type="checkbox"/> Multiple		
7. Number of unplanned VBAC: <input type="checkbox"/> # of primary VBAC, <input type="checkbox"/> # of subsequent VBAC		
8. Number of water births		0
9. Number of births requiring sutures		0
10. Number of births transferred elsewhere for medical reasons		0
11. Number of births transferred elsewhere for non-medical reasons		0
12. Number of births transferred elsewhere for medical reasons		0
13. Number of cesarean deliveries		0
14. Number of live births / stillborn (includes delivery only)		0
15. Number of still births / miscarriages (includes delivery only)		0
16. Number of abortions (includes delivery only)		0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheets as needed.

Class	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	N/A			

Total Number of Antepartum Transfers from all sheets (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	Delivery Method	MOTHER		INFANT	
			Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
	N/A					

Total Intrapartum Transfers from all sheets (3-B)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true

Printed Name: Kristie White
Signature: 
Date Signed: 7/25/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Layla M Swisher License #: MW178
 Practice Name: The Birth Cottage
 Address: 260 E 6 Ave
TLH, FL 32303
 Phone Number: 850-224-2229 Email: BirthCottage@yahoo.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)		
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):				80		
	B	Total number of maternity clients you accepted for care in the reporting period:				80		
	C	Total number of deliveries you performed during reporting period:				41		
	D	Total number of licensed midwife students assigned to you during the reporting period:				3		
	E	How many delivered at: Home:	16	Birthing Ctr:	25	Hospital:	0	41
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:				16		
	I	Number of mothers requiring sutures:				14		
3	A	Number of mothers transferred antepartum (for medical reasons):				22		
	B	Number of mothers transferred intrapartum:				18		
	C	Number of mothers transferred postpartum: (medical reasons)				1		
	D	Number of newborn transfers:				0		
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0		
	B	Number of fetal deaths / neonatal: (within 7 days of life)				0		
	C	Number of maternal deaths: (please submit separate report)				0		

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/15/17	Fetal Demise	U	31	NSVD
7/20/17	Vulvar Varicosities	U	40	NSVD
8/26/17	Breech	U	37	C/S
9/6/17	Twins	U	20	UNK
9/22/17	Pre Eclampsia	U	37	UNK
11/1/17	PIH	U	39	NSVD
11/3/17	PIH	U	36	NSVD
11/23/17	P-ROM	U	35	UNK
12/16/17	Fetal Development	U	21	NSVD
1/4/18	GDM	U	33	UNK
1/6/18	PTL	U	36	NSVD

Total Number of Antepartum Transfers from all sheet (3-A) →

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
6/3/18	FTP-1	V	No	UNK	No	N
6/21/18	PROM	V	No	7/4	No	N
5/28/18	Transverse	C	No	7/10	No	N
5/7/18	FTP-1	V	No	UNK	No	N
4/3/18	FTP-1	V	No	7/6	No	N
3/2/18	Meconium	V	No	6/3	UNK	N
3/12/18	FTP-1	V	No	6/3	UNK	N
1/23/18	FTP-1	V	No	6/7	No	N
11/4/17	FTP-1	-	Unknown	-	-	-
11/10/17	FTP-1	UNK	UNK	UNK	UNK	N
10/18/17	Meconium	UNK	UNK	UNK	UNK	N
9/7/17	Fetal Distress	V	No	7/2	No	N

Total Intrapartum Transfers from all sheets (3-B) →

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Layla M Swisher, LM
Signature: *Layla M Swisher*
Date: 7-3-18

PAID 7/3/18
PAID 7/5/18



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Carol D. Williams **License #:** MW179
Practice Name: Miami Maternity Center
Address: 140 NE 119 Street
Miami, FL 33161

Phone Number: 786-514-1719 **Email:** carol@miamimaternitycenter.net

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					119
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					109
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	5	Birthing Ctr:	104	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	
	H	Number of water births:					53
	I	Number of mothers requiring sutures:					44
3	A	Number of mothers transferred antepartum (for medical reasons):					
	B	Number of mothers transferred intrapartum:					4
	C	Number of mothers transferred postpartum: (medical reasons)					3
	D	Number of newborn transfers:					1
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-A) ANTEPARTUM TRANSFER (Medical Reasons):

Date	Reason for Transfer	Planned/unplanned	GA at transfer	Outcome
7/3/17	Unplanned home birth	Unplanned	38	NSVD
7/5/17	Delivered in car in route	Unplanned	39	NSVD
7/23/17	Preterm	Unplanned	26	NSVD
8/6/17	Preterm	Unplanned	36	C/S
9/18/17	Gestational Diabetes	Planned	28	
11/24/17	Breech	Planned	40	C/S
12/11/17	VBAC / Preterm	Planned	36	C/S
1/13/18	Preterm Placenta Previa	Planned	31	C/S
2/4/18	Preterm	Unplanned	27	C/S
2/5/18	Preterm	Unplanned	36	C/S
2/22/18	Twins	Planned	36	NSVD
4/11/18	Breech	Planned	40	
4/2018	VBAC	Planned	38	C/S
5/7/18	VBAC	Planned	39	NSVD

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Carol D. Williams
Signature: *Carol D. Williams*
Date Signed: 7-31-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Susan Mattox **License #:** MW183
Practice Name: Inspiration Family Birth Center
Address: 434 Grove Avenue, Winter Park, FL 32789
Phone Number: 407-644-5567 **Email:** robyn@midwife.cc

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					1	
	B	Total number of maternity clients you accepted for care in the reporting period:					1	
	C	Total number of deliveries you performed during reporting period:					8	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	2	Birthing Ctr:	6	Hospital:	0	8
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	0	
	H	Number of water births:					3	
	I	Number of mothers requiring sutures:					2	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					1	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	No Events			
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
11/24/2017	Decels, Pre Eclampsia	NSVD	Pre Eclampsia	5 / 0	No	
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	NO EVENTS		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	NO EVENTS		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	No events					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NO EVENTS			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Susan Mattox

Signature: 

Date Signed: 07/31/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Stacey Walden License #: MW 184
 Practice Name: Rosemary Birthing Home
 Address: 800 Central Ave Sarasota FL 34236

Phone Number: 941-330-9966 Email: stacey@rosemarybirthing.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					35	
	B	Total number of maternity clients you accepted for care in the reporting period:					35	
	C	Total number of deliveries you performed during reporting period:					20	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	5	Birthing Ctr:	14	Hospital:	0	19
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	1		1
	H	Number of water births:					13	
	I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					5	
	B	Number of mothers transferred intrapartum:					4	
	C	Number of mothers transferred postpartum: (medical reasons)					1	
	D	Number of newborn transfers:					1	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/3/17	PTL	Unplanned	36.1	NSVD NICU 5 Days
12/29/17	PTL	Unplanned	20.4	NSVD lived 3 hrs
3/21/18	Post dates, failed NST/BPP	Unplanned	41	NSVD Baby in foster care mother homeless
4/2/18	PTL	Unplanned	30.5	NSVD3LB6OZ, DX W INCOMPETENT CERVIX
1/11/18	High risk pregnancy, Thomsens Myotonia Congentia Referred to MFM and neurologist	Planned	31.2	FTP, UNDX Breech in labor in hospital C/S

Total Number of Antepartum Transfers from all sheet (3-A) **5**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
5/3/18	MSAF, Decels 1st stage primip	C/S	Compound presentation	3713	NO,0	NO
11/16/17	FTP 1ST STAGE	NSVD	NONE	3260	YES,1	NO
11/7/17	FTP 1ST STAGE, PAIN RELIEF	NSVD	EPIDURAL	3401.9	NO, 0	NO
7/20/17	PAIN RELIEF, CLIENT CHOICE	C/S	NONE	3657	NO,0	NO

Total Intrapartum Transfers from all sheets (3-B) **4**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
5/30/18	Cord avulsion, retained placenta, PPH	0.5	Manual removal of placenta, cervical repair
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
5/31/18	Retractions, tachypnea	3515	7,10	yes, 2	IV abx neg cultures, DC TO HOME
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS**(4-A) STILLBIRTH (midwife delivered only)**

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: STACEY WALDEN

Signature: STACEY WALDEN

Date Signed: 7/16/17

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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Council of Licensed Midwifery
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kimberly Lukat License #: 184
 Practice Name: _____
 Address: 2904 SW Mariposa Circle
Palm City, FL 34990
 Phone Number: 772-323-8554 Email: KimberlyLukat@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number			Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	0
	B	Total number of maternity clients you accepted for care in the reporting period:	
	C	Total number of deliveries you performed during reporting period:	
	D	Total number of licensed midwife students assigned to you during the reporting period:	
E	How many delivered at: Home: <input type="checkbox"/> Birthing Ctr: <input type="checkbox"/> Hospital: <input type="checkbox"/>		
F	Number of unplanned: Breech: <input type="checkbox"/> Twins / Multiples: <input type="checkbox"/>		
G	Number of planned VBAC: <input type="checkbox"/> # of primary VBAC: <input type="checkbox"/> # of subsequent VBAC: <input type="checkbox"/>		
H	Number of water births:		
I	Number of mothers requiring sutures:		
3	A	Number of mothers transferred antepartum (for medical reasons):	
	B	Number of mothers transferred intrapartum:	
	C	Number of mothers transferred postpartum: (medical reasons)	
	D	Number of newborn transfers:	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	
	B	Number of fetal deaths / neonatal: (within seven days of birth)	
	C	Number of maternal deaths: (please submit separate report)	

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death

Total Number of Fetal/Neonatal Deaths (4-B)

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached Total Number of Maternal Deaths (4-C) 1

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kimberly Lukat (Not Practicing)
Signature: [Handwritten Signature]
Date Signed: 8/1/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Diana Janopaul, LM License #: MW191
 Practice Name: Where the Heart Is Midwifery
 Address: 141 Covey Ridge West
Tallahassee FL 32312
 Phone Number: (850) 556-7491 Email: heartmidwifery@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					23
	B	Total number of maternity clients you accepted for care in the reporting period:					23
	C	Total number of deliveries you performed during reporting period:					30 ²⁶
	D	Total number of licensed midwife students assigned to you during the reporting period:					1
	E	How many delivered at: Home:	26	Birthing Ctr:	0	Hospital:	0
3	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	4	
	H	Number of water births:					4
3	I	Number of mothers requiring sutures:					8
	A	Number of mothers transferred antepartum (for medical reasons):					9 34 5
	B	Number of mothers transferred intrapartum:					19 80
	C	Number of mothers transferred postpartum: (medical reasons)					1
4	D	Number of newborn transfers:					1
	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
8/9/17	hemorrhage	24 hrs.	stable p̄ transfusion
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
2/16/18	poor respiratory effort	8-2	6/7	NO	Came home p̄ 2 hrs - deep suctioned in hospital
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

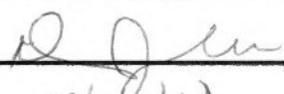
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Diane Janopaul, Lm

Signature: 

Date Signed: 7/29/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: ONIDIS LOPEZ License #: MW192
 Practice Name: NOT CURRENTLY PRACTICING MIDWIFERY
 Address: 1551 NW 26 ST
MIAMI, FL 33142
 Phone Number: 954 802 0981 Email: onidis@icloud.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					N/A
	B	Total number of maternity clients you accepted for care in the reporting period:					N/A
	C	Total number of deliveries you performed during reporting period:					N/A
	D	Total number of licensed midwife students assigned to you during the reporting period:					N/A
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:	N/A
	F	Number of unplanned:	Breech:	Twins / Multiples			N/A
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		N/A
	H	Number of water births:					N/A
	I	Number of mothers requiring sutures:					N/A
3	A	Number of mothers transferred antepartum (for medical reasons):					N/A
	B	Number of mothers transferred intrapartum:					N/A
	C	Number of mothers transferred postpartum: (medical reasons)					N/A
	D	Number of newborn transfers:					N/A
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					N/A
	B	Number of fetal deaths / neonatal: (within 7 days of life)					N/A
	C	Number of maternal deaths: (please submit separate report)					N/A

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	N/A			
				Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
	N/A					
						Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
	N/A				
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

N/A

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: ONILAS LOPEZ

Signature: 

Date: 6/30/2018



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Crystal Topel **License #:** MW194
Practice Name: Inspiration Family Birth Center - NOT CURRENTLY PRACTICING
Address: 434 Grove Avenue, Winter Park, FL 32789

Phone Number: 407-644-5567 **Email:** godmadethemoon@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	0
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	NO EVENTS			
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
	NO EVENTS					
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	NO EVENTS		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	No Events		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NO EVENTS					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NO EVENTS			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Crystal Topel

Signature: 

Date Signed: 07/31/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
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 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Harmony Miller LM, CPM **License #:** MW195
Practice Name: Rosemary Birthing Home
Address: 800 Central Ave. Sarasota, Florida 34236

Phone Number: 941-330-9966 **Email:** Harmony@rosemarybirthing.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					28	
	B	Total number of maternity clients you accepted for care in the reporting period:					27	
	C	Total number of deliveries you performed during reporting period:					23	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	10	Birthing Ctr:	13	Hospital:	0	23
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	2		0
	H	Number of water births:					16	
	I	Number of mothers requiring sutures:					7	
3	A	Number of mothers transferred antepartum (for medical reasons):					4	
	B	Number of mothers transferred intrapartum:					2	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
9/8/17	Twin gestation	Planned	20.6	NSVD Twin A, CS Twin B
1/19/18	Elevated Thyroid level, Gallstones	Planned	26	Unknown
4/30/18	Elevated Thyroid level, Dilated Fetal Bowel	Planned	34.2	NSVD 4lb15oz, PTL Fetal Bowel WNL
6/14/18	Desires TAB DT NTD and Clubbed Foot	Planned	21	TAB
Total Number of Antepartum Transfers from all sheet (3-A)				4

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
12/20/17	FTP 1st stage	NSVD	Jaundice, in room bili lights	UNK	NO, 0	NO
11/24/17	Breech in labor 1st stage multip	C/S	None	UNK	NO, 0	No
Total Intrapartum Transfers from all sheets (3-B)						2

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Harmony Miller LM, CPM

Signature: *Harmony A. Miller*

Date Signed: 7/16/17

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ License #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					
	B	Total number of maternity clients you accepted for care in the reporting period:					
	C	Total number of deliveries you performed during reporting period:					
	D	Total number of licensed midwife students assigned to you during the reporting period:					
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:	
	F	Number of unplanned: Breech:		Twins / Multiples			
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		
	H	Number of water births:					
	I	Number of mothers requiring sutures:					
3	A	Number of mothers transferred antepartum (for medical reasons):					
	B	Number of mothers transferred intrapartum:					
	C	Number of mothers transferred postpartum: (medical reasons)					
	D	Number of newborn transfers:					
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					
	B	Number of fetal deaths / neonatal: (within seven days of birth)					
	C	Number of maternal deaths: (please submit separate report)					

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

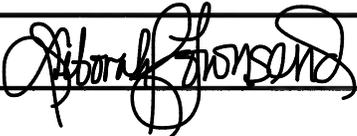
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____
Signature:  _____
Date Signed: _____

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Erlene Destra License #: 204
 Practice Name: _____
 Address: 23183 Cherry Ave
Port Charlotte, FL 33980
 Phone Number: 941-258-6525 Email: femmessage@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	0
	B	Total number of maternity clients you accepted for care in the reporting period:	0
	C	Total number of deliveries you performed during reporting period:	0
	D	Total number of licensed midwife students assigned to you during the reporting period:	0
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____	0
	F	Number of unplanned: Breech: _____ Twins / Multiples: _____	0
	G	Number of planned VBAC: _____ # of primary VBAC: _____ # of subsequent VBAC: _____	0
	H	Number of water births:	0
	I	Number of mothers requiring sutures:	0
	3	A	Number of mothers transferred antepartum (for medical reasons):
B		Number of mothers transferred intrapartum:	0
C		Number of mothers transferred postpartum: (medical reasons)	0
D		Number of newborn transfers:	0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	0
	B	Number of fetal deaths / neonatal: (within seven days of birth)	0
	C	Number of maternal deaths: (please submit separate report)	0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Erline Destra
 Signature: 
 Date Signed: 8/27/15

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

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Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov



ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Christine Simonetta License #: MW207
 Practice Name: Chrysalis Midwifery + Homebirth Svc, Inc
 Address: 870 Karen Dr.
Titusville, FL 32780
 Phone Number: 321-544-8991 Email: Christine.Simonetta@icloud.com
 Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB client visits. include both clients accepted for care and those clients initially seen but not accepted into your care: 34	
	B	Total number of maternity clients you accepted for care in the reporting period: 29	
	C	Total number of deliveries you performed during reporting period: 18	
	D	Total number of licensed midwife students assigned to you during the reporting period: 0	
	E	How many delivered at: Home: 18 Birthing Ctr: 0 Hospital: 0 18	
F	Number of unplanned: Breech: 0 Twins / Multiples: 0	0	
	G	Number of planned VBAC: / # of primary VBAC: 0 # of subsequent VBAC: 1	1
H	Number of water births:	1	
	I	Number of mothers requiring sutures:	4
	3	A	Number of mothers transferred entapertum (for medical reasons): 2
B		Number of mothers transferred Intrapertum: 0	
C		Number of mothers transferred postpartum: (medical reasons) 0	
D		Number of newborn transfers: 0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0	
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0	
	C	Number of maternal deaths: (please submit separate report) 0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
1.25.18	PIH	Planned	39.4	NSVD
6.6.18	PIH	planned	38.5	NSVD

Total Number of Antepartum Transfers from all sheet (3-A) **2**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?

Total Intrapartum Transfers from all sheets (3-B) **0**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)				
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	
0	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Christine Simone

Signature: *Christine Simone*

Date Signed: 7.30.18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Ada Sprouse License #: mw208
 Practice Name: _____
 Address: 2316 Hollywood Blvd
Hollywood, FL 33020
 Phone Number: (786) 513-0975-9222 Email: beckysprouse@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					22	
	B	Total number of maternity clients you accepted for care in the reporting period:					20	
	C	Total number of deliveries you performed during reporting period: 21					21	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	18	Birthing Ctr:	3	Hospital:	0	21
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:					14	
	I	Number of mothers requiring sutures:					2	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					1	
	C	Number of mothers transferred postpartum: (medical reasons) Retained Placenta					1	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
12/18/17	Retained Placenta	1	WNL

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Ada Spouse
Signature: 
Date Signed: 7/5/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Karin L. Pugh **License #:** MW209
Practice Name: Loving Arms Birth & Wellness Center, LLC
Address: 1111 NE 25th Avenue - Ste 201
 Ocala, FL 34470
Phone Number: 352-612-0657 **Email:** karinpugh@yahoo.com

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number								Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:						46
	B	Total number of maternity clients you accepted for care in the reporting period:						46
	C	Total number of deliveries you performed during reporting period:						9
	D	Total number of licensed midwife students assigned to you during the reporting period:						2
	E	How many delivered at: Home:	2	Birthing Ctr:	7	Hospital:	0	
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		
	H	Number of water births:						3
	I	Number of mothers requiring sutures:						1
3	A	Number of mothers transferred antepartum (for medical reasons):						6
	B	Number of mothers transferred intrapartum:						0
	C	Number of mothers transferred postpartum: (medical reasons)						0
	D	Number of newborn transfers:						0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)						0
	B	Number of fetal deaths / neonatal: (within seven days of birth)						0
	C	Number of maternal deaths: (please submit separate report)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS N/A

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant) N/A

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0	
Total Number of Maternal Deaths (4-C)		

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Karin L. Pugh, LM

Signature: 

Date Signed: 07/20/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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ANNUAL REPORT OF MIDWIFERY PRACTICE

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SECTION I: PRACTICE INFORMATION

Midwife Name: Daffini H Terrell License #: mw 210
 Practice Name: Midwife Hope Terrell LLC
 Address: 4714 Birkenhead Rd
Jacksonville, FL 32210
 Phone Number: 904-476-2999 Email: hope@bcofjax.com

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					110
	B	Total number of maternity clients you accepted for care in the reporting period:					110
	C	Total number of deliveries you performed during reporting period:					30
	D	Total number of licensed midwife students assigned to you during the reporting period:					2
	E	How many delivered at: Home:	14	Birthing Ctr:	16	Hospital:	0
F	Number of unplanned: Breech:	0	Twins / Multiples	0			
G	Number of planned VBAC: 2	# of primary VBAC:	0	# of subsequent VBAC:	2	2	
H	Number of water births:					26	
I	Number of mothers requiring sutures:					1	
3	A	Number of mothers transferred antepartum (for medical reasons):					1
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

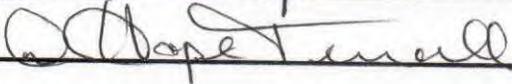
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Daffin Hope Terrell
Signature: 
Date Signed: 7-26-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: LYNN DEER License #: 214
 Practice Name: _____
 Address: 5664 Bear Stone Run
Orlando, FL 32765
 Phone Number: 407-463-9338 Email: lynndeer@mac.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):	0
	B Total number of maternity clients you accepted for care in the reporting period:	0
	C Total number of deliveries you performed during reporting period:	0
	D Total number of licensed midwife students assigned to you during the reporting period:	0
	E How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____	0
	F Number of unplanned: Breech: _____ Twins / Multiples: _____	0
	G Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____	0
	H Number of water births:	0
	I Number of mothers requiring sutures:	0
3	A Number of mothers transferred antepartum (for medical reasons):	0
	B Number of mothers transferred intrapartum:	0
	C Number of mothers transferred postpartum: (medical reasons)	0
	D Number of newborn transfers:	0
4	A Number of fetal deaths / stillborn: (midwife delivery only)	0
	B Number of fetal deaths / neonatal: (within 7 days of life)	0
	C Number of maternal deaths: (please submit separate report)	0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Lynn Deor
Signature: *Lynn Deor*
Date Signed: 8/22/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Dana P. Gordon **License #:** MW215
Practice Name: B.O.R.N.
Address: 1255 Normandy Dr., Miami Beach, FL 33141
Phone Number: 305 335-1181 **Email:** Midwiferyborn@gmail.com

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					33
	B	Total number of maternity clients you accepted for care in the reporting period:					33
	C	Total number of deliveries you performed during reporting period:					21
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	22	Birthing Ctr:	0	Hospital:	3
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC: # of primary VBAC:	2	# of subsequent VBAC:	0		
	H	Number of water births:					10
	I	Number of mothers requiring sutures:					11
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					2
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

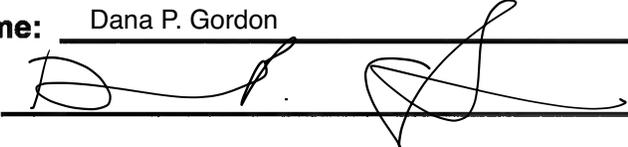
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Dana P. Gordon
Signature: 
Date Signed: 07/16/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Daymarys DelCastillo **License #:** MW217
Practice Name: Serenity holistic OBGYN
Address: 13499 Biscayne Blvd North Miami, Florida 33181
Phone Number: 305-978-8018 **Email:** Daymarysd@gmail.com

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					100
	B	Total number of maternity clients you accepted for care in the reporting period:					100
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					
E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0	
F	Number of unplanned: Breech:	0	Twins / Multiples	0			
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		
H	Number of water births:					0	
I	Number of mothers requiring sutures:					n/a	
3	A	Number of mothers transferred antepartum (for medical reasons):					n/a
	B	Number of mothers transferred Intrapartum:					n/a
	C	Number of mothers transferred postpartum: (medical reasons)					n/a
	D	Number of newborn transfers:					n/a
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

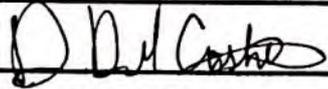
Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
N/A	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Daymarys DelCastillo

Signature: 

Date Signed: 07/30/2018

**Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256**

or

**Email to:
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Amy Olen **License #:** MW218
Practice Name: NA
Address: 16128 271st PI NE
 Duvall, WA 98019
Phone Number: 305-494-5125 **Email:** amyolen@gmail.com

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number								Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:						0
	B	Total number of maternity clients you accepted for care in the reporting period:						0
	C	Total number of deliveries you performed during reporting period:						0
	D	Total number of licensed midwife students assigned to you during the reporting period:						0
	E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC: # of primary VBAC:	0	# of subsequent VBAC:	0			0
	H	Number of water births:						0
	I	Number of mothers requiring sutures:						0
3	A	Number of mothers transferred antepartum (for medical reasons):						0
	B	Number of mothers transferred intrapartum:						0
	C	Number of mothers transferred postpartum: (medical reasons)						0
	D	Number of newborn transfers:						0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)						0
	B	Number of fetal deaths / neonatal: (within seven days of birth)						0
	C	Number of maternal deaths: (please submit separate report)						0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	NA			
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
	NA					
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	NA		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	NA		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NA					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

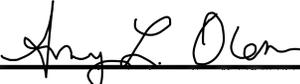
Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NA			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Amy Olen

Signature: 

Date Signed: July 30, 2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

term with severe bleeding that was sent to the hospital prior to admission for labor which would be an Antepartum transfer. A mother in labor and admitted in to your care for delivery who transfers to the hospital would be an Intrapartum Transfer.

Section 3C is the total number of postpartum transfers for medical reasons. This should include all mothers transferred to the hospital after delivery of the baby and within six weeks of the birth. This total should match the total from the Table of Postpartum Transfers.

Section 3D is the total number of newborn transfers. This should include all newborns transferred to a hospital after delivery and within seven days of birth. This total should match the total from the Table of Newborn Transfers.

Section 4A is the total number of stillborn deliveries you attended. This should not include intrapartum transfer patients who went on to deliver the stillborn at the hospital, which should be counted as an Intrapartum Transfer. This total should match the total from the Table of Stillbirths.

Section 4B is the total number of neonatal deaths of babies you delivered. This is any fetal death where the baby was born alive but died within seven days of birth. This total should match the total from the Table of Fetal Death/Neonatal Death.

Section 4C is the total number of maternal deaths of a client in your care. A separate report outlining the details of the maternal death should be submitted with the Annual Report form.

SECTION III. For each of the tables you should document each occurrence during the reporting year. Use the table provided and attach a separate sheet if you need additional lines. Total each table and compare totals to Section II.

Mail completed forms to the Florida Department of health, Council of Licensed Midwifery, 4052 Bald Cypress Way, Bin #C-06, Tallahassee, FL 32399-3256, or email to MQA.Midwifery@FIHealth.gov.

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery 4052 Bald
Cypress Way, Bin #C-06 Tallahassee, FL
32399-3256 MQA.Midwifery@FIHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION	
Midwife Name: <u>Colleen Scarlett</u>	License #: <u>219</u> Practice Name: _____ Address: _____
Phone Number: _____	Email: _____
<u>786 399-6399</u>	

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Section	Description	Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	5
	B	Total number of maternity clients you accepted for care in the reporting period:	5
	C	Total number of deliveries you performed during reporting period:	4
	D	Total number of licensed midwife students assigned to you during the reporting period:	0
	E	How many delivered at: Home: <u>4</u> Birthing Ctr: <u>0</u> Hospital: <u>0</u>	
	F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>	
		# of subsequent VBAC:	

	G	Number of planned VBAC:	# of primary VBAC:		
	H	Number of water births:			3
	I	Number of mothers requiring sutures:			01
3	A	Number of mothers transferred antepartum (for medical reasons):			0
	B	Number of mothers transferred intrapartum:			0
	C	Number of mothers transferred postpartum: (medical reasons)			0
	D	Number of newborn transfers:			0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)			0
	B	Number of fetal deaths / neonatal: (within 7 days of life)			0
	C	Number of maternal deaths: (please submit separate report)			0

SECTION II. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons) List each transfer separately. Do not list names. Attach separate sheets if needed.

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAG, Forceps, C/S)
11/21/17	Baby Breech		34	C/S
Total Number of Antepartum Transfers from all sheet (3-A)				

(3-B) INTRAPARTUM TRANSFERS List each transfer separately. Do not list names. If needed, attach separate sheets if needed.

DATE	REASON FOR TRANSFER	Delivery Method	Complications?	BIRTH WEIGHT	MOTHER		INFANT	
					Admitted to NICU? If yes, reason and # of days	Neonatal Death?		
Total Intrapartum Transfers from all sheets (3-B)								

(3-C) MATERNAL POSTPARTUM TRANSFERS (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	DH-MQA 5011, 05/201504/2017 Rule 64B.24-7.014 F.A.C.		
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION V - DEATHS

Date	(4-A) STILLBIRTH (Cause of Death listed only)	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

DH-MQA 5011, 05/201504/2017
Rule 64B.24-7.014 F.A.C.

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Total Number of Maternal Deaths (4-C)

Printed Name: COLLEEN SCARLETT
 Signature: Colleen Scarlett

Date Signed: 8/30/17

Mail completed forms to: Florida Department
of Health Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06 Tallahassee,
FL 32399-3256

or Email to:

MQA.Midwifery@FHHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: BERENICE ROWELL License #: LM 225
 Practice Name: LABOR OF LOVE BIRTH CENTER
 Address: 106 MYRTLE RIDGE RD,
LETZ FL 33549
 Phone Number: 813 949 1185 Email: BEAMWIFE@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care): 8
	B	Total number of maternity clients you accepted for care in the reporting period: 8
	C	Total number of deliveries you performed during reporting period: 11
	D	Total number of licensed midwife students assigned to you during the reporting period: 2
	E	How many delivered at: Home: 4 Birthing Ctr: 7 Hospital: 0 11
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0
	G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0 0
	H	Number of water births: 4
	I	Number of mothers requiring sutures: 2
3	A	Number of mothers transferred antepartum (for medical reasons): 2
	B	Number of mothers transferred intrapartum: 2
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within 7 days of life) 0
	C	Number of maternal deaths: (please submit separate report) 0

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SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/4/17	FTP	Planned	41:2	
10/9/17	No fetal stomach / polyhydramniotic	Planned	32:6	NSVD
10/9/17	GDM	Planned	33:5	unknown

Total Number of Antepartum Transfers from all sheet (3-A) **2**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7/4/17 4/3/17	FTP	NSVD	none	un Known	NO	NO
7/13/17	FTP / exhaustion	CS	none	9lb 13g	NO	NO

Total Intrapartum Transfers from all sheets (3-B) **2**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: BERENICE ROUELL

Signature: *B. Rouell*

Date: 6/30/18

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Tara L. Dettra, L.M. License #: MW227
 Practice Name: Tara L. Dettra, L.M. / St. Augustine Homebirth
 Address: 5 Palm Row
St. Augustine, FL 32084
 Phone Number: 904-540-7994 Email: taradettra@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):	16
	B	Total number of maternity clients you accepted for care in the reporting period:	17
	C	Total number of deliveries you performed during reporting period:	18
	D	Total number of licensed midwife students assigned to you during the reporting period:	0
	E	How many delivered at: Home: <u>15</u> Birthing Ctr: <u>3</u> Hospital: <u>0</u>	
	F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>	
	G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u>	
	H	Number of water births:	7
	I	Number of mothers requiring sutures:	3
3	A	Number of mothers transferred antepartum (for medical reasons):	3
	B	Number of mothers transferred intrapartum:	1
	C	Number of mothers transferred postpartum: (medical reasons)	1
	D	Number of newborn transfers:	0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	0
	B	Number of fetal deaths / neonatal: (within 7 days of life)	0
	C	Number of maternal deaths: (please submit separate report)	0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

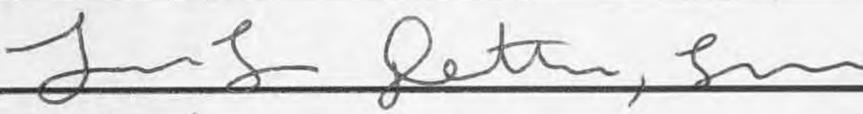
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Tara L. Dettra, L.M.
Signature: 
Date Signed: 7/31/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ **License #:** _____
Practice Name: _____
Address: _____

Phone Number: _____ **Email:** _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____
F	Number of unplanned: Breech: _____ Twins / Multiples _____	
G	Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____	
H	Number of water births: _____	
I	Number of mothers requiring sutures: _____	
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

Signature: _____ 

Date Signed: _____

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: ABIGAIL FLETCHER **License #:** MW229
Practice Name: MIDWIVES COOPERATIVE LLC
Address: 2602 NW 6th Street, Suite B, Gainesville, FL 32609
Phone Number: 352 377 3879 **Email:** midwivescooperative@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					13
	B	Total number of maternity clients you accepted for care in the reporting period:					13
	C	Total number of deliveries you performed during reporting period:					15
	D	Total number of licensed midwife students assigned to you during the reporting period:					2
E	How many delivered at: Home:	15	Birthing Ctr:	0	Hospital:	0	
F	Number of unplanned: Breech:	0	Twins / Multiples	0			
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		
H	Number of water births:					5	
I	Number of mothers requiring sutures:					3	
3	A	Number of mothers transferred antepartum (for medical reasons):					2
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					2
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
11/21/17	3rd degree laceration	not admitted	Sutured as outpatient: excellent
12/24/17	Post-partum hemorrhage	not admitted	D/c home after stabilized in ER
Total Number of Postpartum Transfers from all sheets (3-C)			2

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	NONE		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NONE					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NONE			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: ABIGAIL FLETCHER

Signature: 

Date Signed: 7/12/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kimberly A. Verborg License #: MW230
 Practice Name: Sweet Child O' Mine Inc
 Address: 215 Lithia Penecrest Rd
Brandon Fl 33511
 Phone Number: 813-685-8404 Email: kim@sweetchildbirth.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					115
	B	Total number of maternity clients you accepted for care in the reporting period:					115
	C	Total number of deliveries you performed during reporting period:					27
	D	Total number of licensed midwife students assigned to you during the reporting period:					5
	E	How many delivered at: Home:	7	Birthing Ctr:	20	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	
	H	Number of water births:					13
	I	Number of mothers requiring sutures:					9
3	A	Number of mothers transferred antepartum (for medical reasons):					16
	B	Number of mothers transferred intrapartum:					2
	C	Number of mothers transferred postpartum: (medical reasons)					1
	D	Number of newborn transfers:					1
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

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SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/29/17	Precipitous at 37wk, called 911	unplan	37	NSVD
8/11/17	MAB induced	unplan	16	induced Abortion
8/15/17	PROM @ ctx not admitted	unplan	40	C/S
8/18/17	PROM @ ctx not admitted	unplan	39	NSVD
8/20/17	PROM @ ctx not admitted	unplan	41	NSVD
9/20/17	GHTN	unplan	40	NSVD
10/4/17	IUGR	unplan	37	C/S
10/10/17	PPROM	unplan	27	NSVD
10/27/17	placenta previa	unplan	27	NSVD
12/14/17	postdates	unplan	42	C/S
12/30/17	Breech	unplan	39	C/S
Total Number of Antepartum Transfers from all sheet (3-A)				16

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
2/7/18	FTP Persistent OP	C/S	no	6-4	no	no
4/1/18	FTP 2nd stage	C/S	no	8-6	no	no
Total Intrapartum Transfers from all sheets (3-B)						2

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
2/1/18	PPROM	unplan	24	NSVD @ 34w9d
3/14/18	41 wk postdates, elective induction	unplan	41	NSVD
5/7/18	early labor MSAF not admitted	unplan	41	C/S
5/25/18	need for Makena injections	unplan	16	hopes to return
6/22/18	Breech, ECV failed reaction to epidural	unplan	39	C/S
Total Number of Antepartum Transfers from all sheet (3-A)				16

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
9/25/17	retained placenta	2	WNL, mom + baby good
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
9/8/17	RDS	7.8	6/7	16	released stable, WNL
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

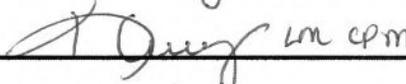
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kimberly A. Verburg

Signature:  LM CPM

Date Signed: 7/14/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: My Hummon License #: MW232
 Practice Name: _____
 Address: 440 E Dearborn St
Englewood, FL 34223
 Phone Number: 41359 2808 Email: myhummon@gmail

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):				19
	B	Total number of maternity clients you accepted for care in the reporting period:				29
	C	Total number of deliveries you performed during reporting period:				19
	D	Total number of licensed midwife students assigned to you during the reporting period:				0
	E	How many delivered at: Home:	Birthing Ctr:	Hospital:		22
	F	Number of unplanned: Breech:	Twins / Multiples			0
	G	Number of planned VBAC:	# of primary VBAC:	# of subsequent VBAC:		1
	H	Number of water births:				10
	I	Number of mothers requiring sutures:				1
3	A	Number of mothers transferred antepartum (for medical reasons):				0
	B	Number of mothers transferred intrapartum:				2
	C	Number of mothers transferred postpartum: (medical reasons)				0
	D	Number of newborn transfers:				0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0
	B	Number of fetal deaths / neonatal: (within 7 days of life)				0
	C	Number of maternal deaths: (please submit separate report)				0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Ivy Hummors
Signature: Ivy Hummors LM,CPM
Date: 6/22/18



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kathryn Albers License #: MW233

Practice Name: none

Address: 2645 Red Fox Rd
Orange Park FL 32073

Phone Number: 414-559-7194 Email: katie.albers@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <input type="text" value="0"/>
	B	Total number of maternity clients you accepted for care in the reporting period: <input type="text" value="0"/>
	C	Total number of deliveries you performed during reporting period: <input type="text" value="0"/>
	D	Total number of licensed midwife students assigned to you during the reporting period: <input type="text" value="0"/>
	E	How many delivered at: Home: <input type="text" value="0"/> Birthing Ctr: <input type="text" value="0"/> Hospital: <input type="text" value="0"/>
F	Number of unplanned: Breech: <input type="text" value="0"/>	Twins / Multiples: <input type="text" value="0"/>
	Number of planned VBAC: # of primary VBAC: <input type="text" value="0"/>	
G	Number of planned VBAC: # of primary VBAC: <input type="text" value="0"/>	# of subsequent VBAC: <input type="text" value="0"/>
H	Number of water births: <input type="text" value="0"/>	
I	Number of mothers requiring sutures: <input type="text" value="0"/>	
3	A	Number of mothers transferred antepartum (for medical reasons): <input type="text" value="0"/>
	B	Number of mothers transferred intrapartum: <input type="text" value="0"/>
	C	Number of mothers transferred postpartum: (medical reasons) <input type="text" value="0"/>
	D	Number of newborn transfers: <input type="text" value="0"/>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <input type="text" value="0"/>
	B	Number of fetal deaths / neonatal: (within seven days of birth) <input type="text" value="0"/>
	C	Number of maternal deaths: (please submit separate report) <input type="text" value="0"/>

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					

Total Number of Fetal Death/Stillborn (4-A) 0

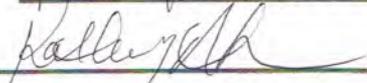
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kathryn Albers
Signature: 
Date Signed: July 20, 2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Enice Romero License #: MW 234
 Practice Name: Non practicing
 Address: 1264 sw 138 place Miami FL 33184

Phone Number: 786 320 0559 Email: placentatree@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
E	How many delivered at: Home: <input type="text"/> Birthing Ctr: <input type="text"/> Hospital: <input type="text"/>	
F	Number of unplanned: Breech: <input type="text"/> Twins / Multiples: <input type="text"/>	
G	Number of planned VBAC: # of primary VBAC: <input type="text"/> # of subsequent VBAC: <input type="text"/>	
H	Number of water births:	
I	Number of mothers requiring sutures:	
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

en
1/30/18

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

Handwritten signature and date: 7/30/18

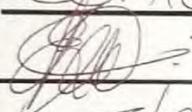
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	1
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Enrica Romero
 Signature: 
 Date Signed: 7/30/2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: ULRIKE UHRIG License #: 235
 Practice Name: MAMA BY NATURE, LLC
 Address: 3609 BAYVIEW RD., MIAMI, FL 33133
 Phone Number: 305-458-7759 Email: ulli.uhrig@icloud.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					3
	B	Total number of maternity clients you accepted for care in the reporting period:					3
	C	Total number of deliveries you performed during reporting period:					2
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	2	Birthing Ctr:	0	Hospital:	1
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		0
	G	Number of planned VBAC: 0	# of primary VBAC:	0	# of subsequent VBAC:	0	0
	H	Number of water births:					1
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

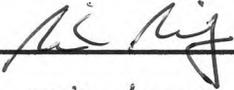
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Ulrike Uhrig
Signature: 
Date Signed: 07/20/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: April Williams License #: MW236
 Practice Name: Natural Design Midwifery
 Address: 1132 Hoffner Ave.
Orlando, FL 32809
 Phone Number: 407-902-8561 Email: naturaldesignmidwifery@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 30
	B	Total number of maternity clients you accepted for care in the reporting period: 30
	C	Total number of deliveries you performed during reporting period: 24
	D	Total number of licensed midwife students assigned to you during the reporting period: 1
	E	How many delivered at: Home: 24 Birthing Ctr: 0 Hospital: 5 29
F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0	
G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 4 4	
H	Number of water births: 15	
I	Number of mothers requiring sutures:	
3	A	Number of mothers transferred antepartum (for medical reasons): 3
	B	Number of mothers transferred intrapartum: 2
	C	Number of mothers transferred postpartum: (medical reasons) 1
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
2/18	Preterm Labor	unplanned	36.4	NSVD
6/18	Preterm Labor	unplanned	36.1	NSVD
8/17	Breech Baby	unplanned	40	C/S

Total Number of Antepartum Transfers from all sheet (3-A) **3**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
4/18	Maternal Exhaustion	Car		7.7	N	N
4/18	Low FHT	Ambulance		7.3	N	N

Total Intrapartum Transfers from all sheets (3-B) **2**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
11/17	3rd degree laceration	0	Good condition
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: April Williams

Signature: April Williams, Rm

Date Signed: 7/26/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)

Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

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ANNUAL REPORT OF MIDWIFERY PRACTICE

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Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Pamela Sheppard Strachan License #: MW 237
 Practice Name: Perfect Choice Doula and Childbirth Services
 Address: 1495 NW 51st Terrace
Miami, FL 33142
 Phone Number: 786-597-3189 Email: holytri3333@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 0
	B	Total number of maternity clients you accepted for care in the reporting period: 0
	C	Total number of deliveries you performed during reporting period: 0
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 0 Birthing Ctr: 0 Hospital: 0
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0
G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0	
H	Number of water births: 0	
I	Number of mothers requiring sutures: 0	
3	A	Number of mothers transferred antepartum (for medical reasons): 0
	B	Number of mothers transferred intrapartum: 0
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					

Total Number of Fetal Death/Stillborn (4-A)

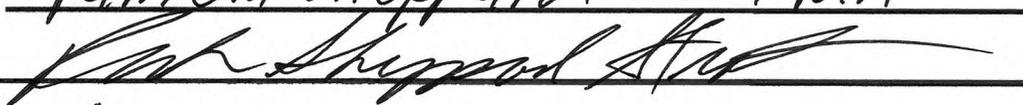
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Pamela Sheppard Strachan
Signature: 
Date Signed: 7/27/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Monique M Moya **License #:** MW238

Practice Name: _____

Address: 2214 NW 15th Way Lot 639 Boynton Beach, FL 33436

Phone Number: 406/561-9466 **Email:** midwifemoniquelm@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0	
	B	Total number of maternity clients you accepted for care in the reporting period:					0	
	C	Total number of deliveries you performed during reporting period:					0	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC: 0	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:					0	
	I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					0	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	n/a			
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
	n/a					
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	n/a		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	n/a		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	n/a					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	n/a			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Monique M Moya

Signature: 

Date Signed: 07/26/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kristen M. Phillips License #: M^W239
 Practice Name: Birth & Wellness Center of Gainesville
 Address: 607 E. University Ave
Gainesville, FL 32608
 Phone Number: 352-278-6160 Email: kmp4midwifery@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <input type="text" value="0"/>	
	B	Total number of maternity clients you accepted for care in the reporting period: <input type="text" value="0"/>	
	C	Total number of deliveries you performed during reporting period: <input type="text" value="0"/>	
	D	Total number of licensed midwife students assigned to you during the reporting period: <input type="text" value="0"/>	
E	How many delivered at: Home: <input type="text" value="0"/>	Birthing Ctr: <input type="text" value="0"/>	Hospital: <input type="text" value="0"/>
	F	Number of unplanned: Breech: <input type="text" value="0"/>	Twins / Multiples: <input type="text" value="0"/>
G	Number of planned VBAC: # of primary VBAC: <input type="text" value="0"/>	# of subsequent VBAC: <input type="text" value="0"/>	
H	Number of water births: <input type="text" value="0"/>		
I	Number of mothers requiring sutures: <input type="text" value="0"/>		
3	A	Number of mothers transferred antepartum (for medical reasons): <input type="text" value="0"/>	
	B	Number of mothers transferred intrapartum: <input type="text" value="0"/>	
	C	Number of mothers transferred postpartum: (medical reasons) <input type="text" value="0"/>	
	D	Number of newborn transfers: <input type="text" value="0"/>	
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <input type="text" value="0"/>	
	B	Number of fetal deaths / neonatal: (within seven days of birth) <input type="text" value="0"/>	
	C	Number of maternal deaths: (please submit separate report) <input type="text" value="0"/>	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A				
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	<i>N/A</i>			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

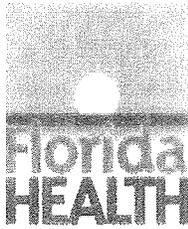
I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kristen M. Phillips
 Signature: *Kristen Phillips, M*
 Date Signed: 7/30/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Ashley Schaffer LM CPM License #: 240
 Practice Name: WF Health Birth Center
 Address: 15255 Max Leggett Parkway Suite 4000
Jacksonville FL 32218
 Phone Number: (904) 427-6378 Email: Ashley.Schaffer@jax.wfl.edu

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					46	
	B	Total number of maternity clients you accepted for care in the reporting period:					44	
	C	Total number of deliveries you performed during reporting period:					33	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	—	Birthing Ctr:	33	Hospital:	—	33
	F	Number of unplanned:	Breech:	Twins / Multiples				0
	G	Number of planned VBAC:	# of primary VBAC:	# of subsequent VBAC:				0
	H	Number of water births:					13	
	I	Number of mothers requiring sutures:					9	
3	A	Number of mothers transferred antepartum (for medical reasons):					5	
	B	Number of mothers transferred intrapartum:					5	
	C	Number of mothers transferred postpartum: (medical reasons)					2	
	D	Number of newborn transfers:					2	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
8/2/17	Gestational HTN : IOL	P	37.5	LTCD
9/5/17	Persistent breech	P	35.5	LTCD
12/4/17	Chronic HTN (upon receipt of records)	P	20.0	NSVD
12/5/17	EFW 2251g AC 45% : IOL per physician	P	37.5	
4/18/18	Gestational diabetes	P	28.5	

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
11/10/17	FTP, Pain relief	VD	∅	6-14.5	-	-
11/15/17	PROM 5 active labor	VD	Cat II FHR	7-9.7	-	-
1/30/18	FTP	CD	∅	7-13	-	-
6/5/18	Lack of descent	VAD VD	∅	7-11	-	-
4/7/18	Fetal tachycardia	VD	∅	4-14	-	-

Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
4/25/18	Repair of extensive laceration 2nd	1d	Stable
6/24/18	Blood transfusion hypo h.O PP (managed PP care only, total EBL 500ml h/o anemia)	2d	Symptomatic
Total Number of Postpartum Transfers from all sheets (3-C)			2

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
2/21/18	RDS	7-9.5	6	Yes	7d - healthy
3/19/18	Persistent grunting	10-4.5	8.9	Yes	4d - healthy
Total Newborn Transfers from all sheets(3-D)					2

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	①					
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	—
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Ashley Schaffer LM CPM
Signature: Ashley Schaffer LM CPM
Date Signed: 7/27/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Misti Balzer License #: MW242
 Practice Name: Growing Families Midwifery Service and BirthCenter
 Address: 3750 US 1 S. St. Augustine FL 32086
 Phone Number: 904-460-2771 Email: balzermidwife@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care): 60
	B	Total number of maternity clients you accepted for care in the reporting period: 54
	C	Total number of deliveries you performed during reporting period: 31
	D	Total number of licensed midwife students assigned to you during the reporting period: 2
	E	How many delivered at: Home: 14 Birthing Ctr: 17 Hospital: 0 31
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0
	G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0
	H	Number of water births: 22
	I	Number of mothers requiring sutures: 6
3	A	Number of mothers transferred antepartum (for medical reasons): 1
	B	Number of mothers transferred intrapartum: 6
	C	Number of mothers transferred postpartum: (medical reasons) 1
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within 7 days of life) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
9/5	4th degree laceration	2	uncomplicated, surgical repair.

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Misti Balzer LM
 Signature: *Misti Balzer*
 Date: 6-12-2018



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Amy Reynolds License #: MW243
 Practice Name: The Ocala Birth Center
 Address: 5455 SE Maricamp Road
Ocala, FL 34480
 Phone Number: 352-286-7681 Email: Amy@apeacefulbeginning.com
Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					57	
	B	Total number of maternity clients you accepted for care in the reporting period:					56	
	C	Total number of deliveries you performed during reporting period:					34	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	1	Birthing Ctr:	33	Hospital:	0	34
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:		# of primary VBAC:	0	# of subsequent VBAC:	0	0
	H	Number of water births:					7	
	I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					3	
	B	Number of mothers transferred intrapartum:					3	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
 			

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
 					

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
 						

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
0				
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Amy Reynolds
Signature: Amy Reynolds Lm
Date Signed: 7/8/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Michelle M. Ruffalo License #: MW244
 Practice Name: Labor of Love Birth Center
 Address: 106 Myrtle Ridge Rd.
Lutz FL 33549
 Phone Number: 813-949-1185 Email: Michelle.laboroflove@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					61
	B	Total number of maternity clients you accepted for care in the reporting period:					61
	C	Total number of deliveries you performed during reporting period:					22
	D	Total number of licensed midwife students assigned to you during the reporting period:					3
	E	How many delivered at: Home:	1	Birthing Ctr:	22	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	
	H	Number of water births:					14
	I	Number of mothers requiring sutures:					4
3	A	Number of mothers transferred antepartum (for medical reasons):					9
	B	Number of mothers transferred intrapartum:					4
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0
	C	Number of maternal deaths: (please submit separate report)					0

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SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/7/17	Breech / PProm	Planned	36.1	C/S
11/30/17	Polyhydramnios	Planned	31.5	NSVD
12/14/17	IUGR / Transverse	Planned	36.5	NSVD
1/8/18	Breech	Planned	36.6	C/S
2/9/18	SVT	Planned	30.2	NSVD
2/19/18	Fetal brain hemorrhage	Planned	25.4	NSVD
4/30/18	Low lying Placenta	Planned	37.3	C/S
4/4/18	Beta Thalassemia	Planned	37 ⁵	still pregnant
4/18/18	Placenta Previa	Planned	22	still pregnant
Total Number of Antepartum Transfers from all sheet (3-A)				9

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		Neonatal Death?
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	
7/15/18	FTP, Maternal Exhaust C/S		Fetal distress	7.13 ^{# 02}	Yes, ↑ Bilirubin	NO
7/16/18	Maternal Exhaust	NSVD	NO	7.4 ^{# 02}	NO	NO
7/25/18	Vaginal Bleeding	NSVD	NO	6.5 ^{# 02}	NO	NO
7/25/18	FTP	NSVD	NO	7.2 ^{# 02}	NO	NO
Total Intrapartum Transfers from all sheets (3-B)						4

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	N/A
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Michelle M. Ruffalo Jm, CPM

Signature: Michelle M. Ruffalo Jm, CPM

Date: 7/1/18



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Sizzly M Auer **License #:** MW245
Practice Name: Childbirth Options, LLC
Address: 27032 Evergreen Chase Drive
Wesley Chapel, FL 33544
Phone Number: 8133816430 **Email:** sauer@cbowc.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					101	
	B	Total number of maternity clients you accepted for care in the reporting period:					67	
	C	Total number of deliveries you performed during reporting period:					14	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	14	Birthing Ctr:	0	Hospital:	0	14
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	2	2	
	H	Number of water births:					9	
	I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					10	
	B	Number of mothers transferred intrapartum:					1	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
8/5/17	preterm labor	unplanned	35	NSVD
8/5/17	POSITIVE DRUG SCREEN	UNPLANNED	30	NSVD
8/1/17	PRETERM LABOR	UNPLANNED	36	NSVD
7/17/17	HEART CONDITION	UNPLANNED	34	UNKNOWN
9/2/17	POLYHYDRAMNIOS	UNPLANNED	41	C/S
9/28/17	PREECLAMPSIA	UNPLANNED	41	NSVD
2/12/18	OVER DUE	UNPLANNED	41	NSVD
2/26/18	OVER DUE	UNPLANNED	41	NSVD
3/1/18	PRETERM	UNPLANNED	36	NSVD
6/12/18	BLEEDING WITH NO LABOR	UNPLANNED	36	C/S

Total Number of Antepartum Transfers from all sheet (3-A) 10

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
11/29/17	FAILURE TO PROGRESS	NSVD	NONE	UNKNOWN	N	N

Total Intrapartum Transfers from all sheets (3-B) 1

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Sizzly M Auer

Signature: _____



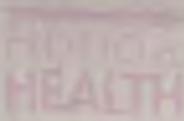
Date Signed: 07/15/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Katherine Sims License #: MW 249

Practice Name: _____

Address: 2245 Fern Dell Place
Los Angeles, CA 90068

Phone Number: 859-559-6888 Email: Katherinesims@me.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2	
A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <input type="checkbox"/>
B	Total number of maternity clients you accepted for care in the reporting period: <input type="checkbox"/>
C	Total number of deliveries you performed during reporting period: <input type="checkbox"/>
D	Total number of licensed midwife students assigned to you during the reporting period: <input type="checkbox"/>
E	How many delivered at: Home: <input type="checkbox"/> Birthing Ctr: <input type="checkbox"/> Hospital: <input type="checkbox"/>
F	Number of unplanned: Breech: <input type="checkbox"/> Twins / Multiples: <input type="checkbox"/>
G	Number of planned VBAC: # of primary VBAC: <input type="checkbox"/> # of subsequent VBAC: <input type="checkbox"/>
H	Number of water births: <input type="checkbox"/>
I	Number of mothers requiring sutures: <input type="checkbox"/>
3	
A	Number of mothers transferred antepartum (for medical reasons): <input type="checkbox"/>
B	Number of mothers transferred intrapartum: <input type="checkbox"/>
C	Number of mothers transferred postpartum: (medical reasons) <input type="checkbox"/>
D	Number of newborn transfers: <input type="checkbox"/>
4	
A	Number of fetal deaths / stillborn: (midwife delivery only) <input type="checkbox"/>
B	Number of fetal deaths / neonatal: (within seven days of birth) <input type="checkbox"/>
C	Number of maternal deaths: (please submit separate report) <input type="checkbox"/>

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Katherine Sims

Signature: Katherine Sims

Date Signed: July 22, 2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Lindsay Meyer License #: MW251
 Practice Name: Loving Hands Midwifery
 Address: 5 Palm Row Saint Augustine Florida 32084
 Phone Number: 9046692538 Email: Lindsay3480@aol.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care): 0
	B	Total number of maternity clients you accepted for care in the reporting period: 0
	C	Total number of deliveries you performed during reporting period: 0
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 0 Birthing Ctr: 0 Hospital: 0 0
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0
	G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0 0
	H	Number of water births: 0
	I	Number of mothers requiring sutures: 0
3	A	Number of mothers transferred antepartum (for medical reasons): 0
	B	Number of mothers transferred intrapartum: 0
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within 7 days of life) 0
	C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Lindsay Meyer

Signature: _____

Date Signed: 8/25/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Christa West **License #:** MW252
Practice Name: Coastal Midwifery
Address: 10200 State Road 84 Suite 207 Davie, FL 33314
Phone Number: 954-648-4990 **Email:** Coastalmidwifery@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					26
	B	Total number of maternity clients you accepted for care in the reporting period:					25
	C	Total number of deliveries you performed during reporting period:					15
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	13	Birthing Ctr:	2	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC: # of primary VBAC:	1	# of subsequent VBAC:	0		
	H	Number of water births:					8
	I	Number of mothers requiring sutures:					2
3	A	Number of mothers transferred antepartum (for medical reasons):					5
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					1
	D	Number of newborn transfers:					2
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
5/20	Dizziness, excessive bleeding	Unplanned	37	C/S
8/29	Low Hemoglobin	Unplanned	36	NSVD
10/17	Low platelets	Unplanned	36	NSVD
9/25	SROM- Heavy meconium	Unplanned	41	C/S
1/30	Pre-Eclampsia	Unplanned	35	NSVD

Total Number of Antepartum Transfers from all sheet (3-A) 5

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
4/15	Elevated BP	NSVD	None	7.8	No	No

Total Intrapartum Transfers from all sheets (3-B) 1

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
2/20	Postpartum Hemorrhage	5 hours	Received fluids, discharge in stable condition 5 hours later
12/15	3rd degree tear	10 hours	Tear sutured in OR, clients discharge after suturing was completed
Total Number of Postpartum Transfers from all sheets (3-C)			2

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
1/1	Tachypnea	8lbs4oz	10/10	24 hours	Healthy Baby boy, TTN
5/4	Jaundice	9lbs9oz	9/9	2 days	Healthy baby boy responded well to UV lights
Total Newborn Transfers from all sheets(3-D)					2

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

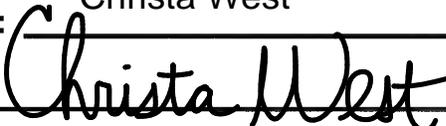
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Christa West

Signature: 

Date Signed: 7/16/18

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Geleena Hinkley License #: MW 253
 Practice Name: Peaceful Pregnancy Pathways
 Address: 1901 NW 81st Ave
Coral Springs, FL 33071
 Phone Number: 954 780 9033 Email: info@p3birth.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					34
	B	Total number of maternity clients you accepted for care in the reporting period:					34
	C	Total number of deliveries you performed during reporting period:					24
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	24	Birthing Ctr:		Hospital:	10
3	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	4	# of subsequent VBAC:	0	
	H	Number of water births:					9
3	I	Number of mothers requiring sutures:					10
	A	Number of mothers transferred antepartum (for medical reasons):					7
	B	Number of mothers transferred intrapartum:					3
	C	Number of mothers transferred postpartum: (medical reasons)					0
4	D	Number of newborn transfers:					0
	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

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 JUL 11 2018
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(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Gaelena Hinkley
Signature: *Gaelena Hinkley*
Date Signed: 7/7/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Mirlande Casseus License #: MW 255
 Practice Name: Full Of Life Midwifery
 Address: 2316 Hollywood Blvd Hollywood, Fl 33020
 Phone Number: 305-343-5906 Email: mirlande.casseus@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					54	
	B	Total number of maternity clients you accepted for care in the reporting period:					54	
	C	Total number of deliveries you performed during reporting period:					34	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	19	Birthing Ctr:	8	Hospital:	4	31
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			
	G	Number of planned VBAC:	# of primary VBAC:	12	# of subsequent VBAC:	10	22	
	H	Number of water births:					23	
	I	Number of mothers requiring sutures:					8	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					0	
	C	Number of mothers transferred postpartum: (medical reasons)					1	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
6/2/18	Postpartum Hemorrhage	2 days	Blood transfusion, Observed then discharged.
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

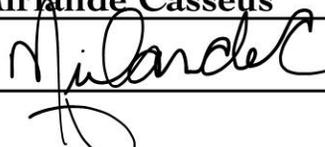
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Mirlande Casseus
Signature:  LM, CPM
Date: 07/12/18



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bln #C-06
 Tallahassee, FL 32399-3256
MOA.Midwifery@FLHealth.gov

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: JAlieet delas Mercedes Canosa License #: MW 257
 Practice Name: JAlieet
 Address: 726 SE 12th Ave
Cape Coral FL 33990
 Phone Number: 639-204 8850 Email: JAlieet Canosa1970@gmail.com
 Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II: CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number	Total(s)
2 A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 0
B	Total number of maternity clients you accepted for care in the reporting period: 0
C	Total number of deliveries you performed during reporting period: 0
D	Total number of licensed midwife students assigned to you during the reporting period: 0
E	How many delivered at: Home: Birthing Ctr: Hospital: 0
F	Number of unplanned: Breech: Twins / Multiples: 0
G	Number of planned VBAC: # of primary VBAC: # of subsequent VBAC: 0
H	Number of water births: 0
I	Number of mothers requiring sutures: 0
3 A	Number of mothers transferred antepartum (for medical reasons): 0
B	Number of mothers transferred intrapartum: 0
C	Number of mothers transferred postpartum: (medical reasons) 0
D	Number of newborn transfers: 0
4 A	Number of fetal deaths / stillborn: (midwife delivery only) 0
B	Number of fetal deaths / neonatal: (within seven days of birth) 0
C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	Ø		
Total Number of Postpartum Transfers from all sheets (3-C)			Ø

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
	Ø		/ / / / /		
Total Newborn Transfers from all sheets(3-D)					Ø

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	Ø					
Total Number of Fetal Death/Stillborn (4-A)						Ø

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name:

Tahira de las Mercedes Carrero

Signature:

Tahira

Date Signed:

7/31/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3266

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

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SECTION I: PRACTICE INFORMATION

Midwife Name: Marisel Sanchez License #: MW 259
 Practice Name: _____
 Address: 787 Glendale Ln Orange Park.
FL 32065
 Phone Number: _____ Email: milinkalili@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number					Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:			0
	B	Total number of maternity clients you accepted for care in the reporting period:			0
	C	Total number of deliveries you performed during reporting period:			0
	D	Total number of licensed midwife students assigned to you during the reporting period:			0
	E	How many delivered at: Home:	Birthing Ctr:	Hospital:	0
F	Number of unplanned:	Breech:	Twins / Multiples	0	
	Number of planned VBAC:	# of primary VBAC:	# of subsequent VBAC:	0	
H	Number of water births:			0	
I	Number of mothers requiring sutures:			0	
3	A	Number of mothers transferred antepartum (for medical reasons):			0
	B	Number of mothers transferred intrapartum:			0
	C	Number of mothers transferred postpartum: (medical reasons)			0
	D	Number of newborn transfers:			0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)			0
	B	Number of fetal deaths / neonatal: (within seven days of birth)			0
	C	Number of maternal deaths: (please submit separate report)			0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Margel Sanchez
Signature: 
Date Signed: 7/20/2019

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32389-3256
MQA.Midwifery@FLHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Rebecca Luckey License #: MW260
 Practice Name: Wholistic Midwifery Services, Inc
 Address: 1381 Dandelion Drive
Delta, FL 32725
 Phone Number: (407) 398-2646 Email: wholisticmidwife@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 35
	B	Total number of maternity clients you accepted for care in the reporting period: 35
	C	Total number of deliveries you performed during reporting period: 19
	D	Total number of licensed midwife students assigned to you during the reporting period: 2
	E	How many delivered at: Home: 19 Birthing Ctr: 0 Hospital: 0 19
F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0	
G	Number of planned VBAC: # of primary VBAC: 1 # of subsequent VBAC: 0 1	
H	Number of water births: 15	
I	Number of mothers requiring sutures: 2	
3	A	Number of mothers transferred antepartum (for medical reasons): 2
	B	Number of mothers transferred intrapartum: 1
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/7/17	IUGR	Planned	36	C/S
11/15/17	PROM, PTL	Unplanned	35	NSVD

Total Number of Antepartum Transfers from all sheet (3-A) **2**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
8/11/17	FTP, Primary UBAC Non-Reassuring FHT	NSVD	No	7.5 ⁺	No	No

Total Intrapartum Transfers from all sheets (3-B) **1**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

0

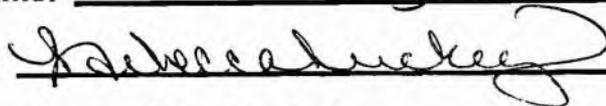
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Rebecca Luckey
Signature: 
Date Signed: 7-13-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**STATE OF FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

LICENSED MIDWIFE ANNUAL REPORT

Report data from July 1 through June 30 of each year. Reports are due no later than July 31..

SECTION 1: PRACTICE INFORMATION

Midwife Name: Marguerite McCarthy License#: MW261
 Practice Name: Birth In Awareness Homebirth and Midwifery Services, Inc.
 Address: 1082 Black Acre Tr.
Winter Springs, FL 32708
 Phone Number: 407-234-7482 Email: Maggiemidwife723@gmail.com

SECTION II. CLIENT CARE SERVICES (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					44
	B	Total number of maternity clients accepted for care in the reporting period:					44*
	C	Total number of deliveries you performed during reporting period:					17
	D	Total number of licensed midwife student assigned to the practice during the reporting period					2
	E	How many delivered at: Home:	17	Birthing Ctr:	0	Hospital:	0
	F	Number of Planned:	0	Twins / Multiples	0		
	G	Number of Planned VBAC:	# of Primary VBAC:	12	# of Subseq. VBAC:	3	
	H	Number of VBAC Successfully Delivered by you: # of Primary		3	# of Subseq:	3	
	HJ	Number of water births:					7
	IJ	Number of mothers requiring sutures:					4
3	A	Number of mothers transferred antepartum (for medical reasons):					2
	B	Number of mothers transferred intrapartum:					5
	c	Number of mothers Transferred postpartum: (medical reasons)					1
	D	Number of Newborn Transfers					0
4	A	Number of Fetal Deaths / Stillborn (midwife delivery only)					0
	B	Number of Fetal Deaths / Neonatal (within 7 days of life)					0
	C	Number of Maternal Deaths (please submit separate report)					0

* 2B- 4 transferred out of care for non-medical reasons
 2H planned hospital births - 6 all primary VBAC's

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
10/23/17	Retained Placenta	0	Dx after manual removal

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Marguerite McCarthy

Signature: MCMcCarthy, Lm.cpm

Date: 7/21/18

Please mail your completed Annual Report to:

Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way
Bin C-06
Tallahassee, FL 32399-3255

Or Fax to: (850) 921-6184



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kristin Schuchmann License #: MW262

Practice Name: Lifesong Midwifery, Inc.

Address: 2575 N. Toledo Blvd, Blvd #3
North Port, FL 34289

Phone Number: 941-423-4342 Email: lifesongmidwife@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 48
	B	Total number of maternity clients you accepted for care in the reporting period: 48
	C	Total number of deliveries you performed during reporting period: 37
	D	Total number of licensed midwife students assigned to you during the reporting period: 1
E	How many delivered at: Home: 37 Birthing Ctr: 0 Hospital: 0 37	
	F Number of unplanned: Breech: 0 Twins / Multiples: 0 0	
G	Number of planned VBAC: 6 # of primary VBAC: 2 # of subsequent VBAC: 2 10	
H	Number of water births: 13	
I	Number of mothers requiring sutures: 8	
3	A	Number of mothers transferred antepartum (for medical reasons): 3
	B	Number of mothers transferred intrapartum: 2
	C	Number of mothers transferred postpartum: (medical reasons) 1
	D	Number of newborn transfers: 1
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 1
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
2-17-18	mother unable to void	< 1	stable, able to void
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
2-17-18	unresponsive to neonatal resus.		0/0	no	neonatal death
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
2-17-18	undetermined, no autopsy performed	2-17-18	8lbs 6oz	< 1 hr
Total Number of Fetal/Neonatal Deaths (4-B)				1

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kristin Schuchmann

Signature: *Kristin Schuchmann*

Date Signed: 07-23-2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Priscilla Kramer **License #:** 263
Practice Name: Midwife Priscilla, LLC
Address: 14300 Lake Pickett Rd
 Orlando, FL 32826
Phone Number: 407-473-1882 **Email:** midwifepriscilla@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC: 0	# of primary VBAC:	0	# of subsequent VBAC:	0	0
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Priscilla Kramer

Signature: *Priscilla Kramer*

Date Signed: July 17, 2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Mary Rainer License #: MW 264
 Practice Name: Birth Blossoms
 Address: 1903 Sunrise Blvd
Fort Pierce Fl 34950
 Phone Number: 724758560 Email: mam@bellsouth.net

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					39	
	B	Total number of maternity clients you accepted for care in the reporting period:					37	
	C	Total number of deliveries you performed during reporting period:					14	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	14	Birthing Ctr:	0	Hospital:	2	16
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			
	G	Number of planned VBAC: 3	# of primary VBAC: 1	# of subsequent VBAC:	2			3
	H	Number of water births:					6	
	I	Number of mothers requiring sutures:					9	
3	A	Number of mothers transferred antepartum (for medical reasons):					2	
	B	Number of mothers transferred intrapartum:					2	
	C	Number of mothers transferred postpartum: (medical reasons)					2	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

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SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
2/12/18	Abnormal fetal finding on US SRMP	planned	37 ^{1/2}	NSVD
Total Number of Antepartum Transfers from all sheet (3-A)				1

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
8/5/17	non reassuring FHT	c/s	non reassuring decel	8#1	no	no
9/13/17	non reassuring FHT	c/s	repeat c/s	9#2	no	no
Total Intrapartum Transfers from all sheets (3-B)						2

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
7/1/17	refusal of care p/p anxiety	2	repaired tear, DIC WNL
12/1/17	3° perineal tear (perianal)	0	outpatient, repaired

Total Number of Postpartum Transfers from all sheets (3-C) 2

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) -

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) -

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Mary Rainer
Signature: *M Rainer*
Date: 7/19/18

email MQA.Midwifery@FlHealth.gov
FLNOM Council of Licensed Midwifery
4052 Bald Cypressway Bin C-06
Tallahassee 32399-3256



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Terri Williams **License #:** MW265
Practice Name: Beautiful Birthings
Address: 1206 Chelsea Place Orlando FL 32803
Phone Number: 321-604-6503 **Email:** terri@bbirth.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					27
	B	Total number of maternity clients you accepted for care in the reporting period:					27
	C	Total number of deliveries you performed during reporting period:					11
	D	Total number of licensed midwife students assigned to you during the reporting period:					1
	E	How many delivered at: Home:	11	Birthing Ctr:	0	Hospital:	9
	F	Number of unplanned: Breech:	1	Twins / Multiples	0		
	G	Number of planned VBAC: # of primary VBAC:	0	# of subsequent VBAC:	1		
	H	Number of water births:					4
	I	Number of mothers requiring sutures:					7
3	A	Number of mothers transferred antepartum (for medical reasons):					3
	B	Number of mothers transferred intrapartum:					4
	C	Number of mothers transferred postpartum: (medical reasons)					2
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
4/25/18	Anemia	Planned	39	NSVD
4/5/18	Breech Presentation	Planned	38	C/S
12/26/17	Post Dates (42 weeks)	Planned	42	C/S

Total Number of Antepartum Transfers from all sheet (3-A) **3**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
2/25/18	Breech	C/S	None	7/0	no	no
2/21/18	Failure to progress	NSVD	None	8/3	no	no
11/21/17	Failure to progress	NSVD	None	7/15	no	no
9/29/17	Failure to progress	NSVD	None	7/11	no	no

Total Intrapartum Transfers from all sheets (3-B) **4**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
3/28	PPH and 3rd degree laceration	2	Healthy, normal
12/9	Cord avulsion, retained placenta	2	healthy, normal
Total Number of Postpartum Transfers from all sheets (3-C)			2

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Terri Williams, LM

Signature: 

Date Signed: 4/26/18

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Rebecca Frichsen License #: MW2666
 Practice Name: Sweet Baby Midwifery
 Address: 1400 S. Orlando Ave Ste 320
Winter Park, FL 32789

Phone Number: 321 279 2760 Email: becky@sweetbabymidwifery

Email addresses are public records. If you do not want your email address released pursuant to a public records request, do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II, CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					66	
	B	Total number of maternity clients you accepted for care in the reporting period:					66	
	C	Total number of deliveries you performed during reporting period:					43	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	41	Birthing Ctr:	2	Hospital:	0	43
	F	Number of unplanned: Breech:	0	Twins / Multiples:	0			0
	G	Number of planned VBAC:	# of primary VBAC:	2	# of subsequent VBAC:	2		4
	H	Number of water births:					21	
	I	Number of mothers requiring sutures:					9	
3	A	Number of mothers transferred antepartum (for medical reasons):					6	
	B	Number of mothers transferred intrapartum:					6	
	C	Number of mothers transferred postpartum: (medical reasons)					4	
	D	Number of newborn transfers:					2	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
10/10 2017	Low AFI	unplanned	41 ²	C/S
10/24 2017	GDM, mFM determined High Risk, PTL	unplanned	30	NSVD
12/30 2017	planned hospital birth	planned	41	NSVD
1/15 2018	HTN	unplanned	32	NSVD
1/20 2018	pt requested induction for postdates	planned	41 ⁰	C/S
5/17 2018	decreased fetal movement	unplanned	40 ¹	NSVD
 				

Total Number of Antepartum Transfers from all sheet (3-A) **6**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
8/27 2017	Loss of consciousness at 8cm	NSVD	none	8lb8	no	no
9/28 2017	 					
10/20 2017	FTP 2nd stage, decels	C/S	sepsis	6#10	yes 9 days	no
11/15 2017	FTP 5cm	C/S	failed VBAC none	7#4	no	no
12/22 2017	PROM from birthcenter		unknown	unknown		
1/22 2018	PROM	NSVD	none	7#5	no	no
2/20 2018	Requesting pain management	C/S	failed VBAC	8#4	no	no
 						
 						
 						
 						
 						

Total Intrapartum Transfers from all sheets (3-B) **6**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
9/28 2017	Retained placenta	36hr	stable
10/11 2017	fever at 48hrs pp	2 days	stable after Abx
10/23 2017	Retained placenta - PPH	2 days	blood transfusion, stable
4/12 2018	Retained membranes @ 6 days pp	12 hrs	stable

Total Number of Postpartum Transfers from all sheets (3-C)

4

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
1/28 2017	Chest compressions required	7#8	2/7	3 days	stable, off O ₂ at 36hrs
2/28 2018	sent by ped, suspected MRSA ^{at 3 days old}	8#9	9/9	1 day	Abx, stable

Total Newborn Transfers from all sheets(3-D)

2

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Rebecca Erichsen
Signature: *Rebecca Erichsen*
Date Signed: 7/25/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: KAITLAN CLOWER-MONEY **License #:** MW267
Practice Name: NOT IN PRACTICE
Address: 6560 KREEGER FARM RD. TOBACCOVILLE NC 27050
Phone Number: 336-480-4112 **Email:** KAITLANCMONEY@GMAIL.COM

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:	0
	F	Number of unplanned: Breech:		Twins / Multiples			0
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		0
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

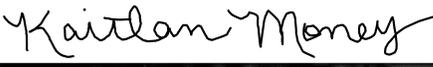
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: KAITLAN CLOWER- MONEY

Signature: 

Date Signed: 07/18/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Katrina Hollon License #: MW268
 Practice Name: Holistic Maternity
 Address: 10460 Roosevelt Blvd Suite 179

Phone Number: 727-565-8798 Email: holisticmaternity@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)		
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:				14		
	B	Total number of maternity clients you accepted for care in the reporting period:				14		
	C	Total number of deliveries you performed during reporting period:				10		
	D	Total number of licensed midwife students assigned to you during the reporting period:				0		
	E	How many delivered at: Home:	87	Birthing Ctr:	0	Hospital:	3	10
	F	Number of unplanned: Breech:	0	Twins / Multiples:	0			0
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	0		1
	H	Number of water births:				5		
	I	Number of mothers requiring sutures:				4		
3	A	Number of mothers transferred antepartum (for medical reasons):				0		
	B	Number of mothers transferred intrapartum:				2		
	C	Number of mothers transferred postpartum: (medical reasons)				0		
	D	Number of newborn transfers:				0		
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0		
	B	Number of fetal deaths / neonatal: (within seven days of birth)				0		
	C	Number of maternal deaths: (please submit separate report)				0		

K. Hollon

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
N/A				
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Katrina Holton
Signature: 
Date Signed: 01/01/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Callie Bench-Izor License #: MW 269
 Practice Name: Callie Bench Midwife
 Address: 610 Ellendale Pr
Winter Park FL 32792
 Phone Number: 407-461-5127 Email: midwife.callie@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2 A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <u>2</u>
B	Total number of maternity clients you accepted for care in the reporting period: <u>2</u>
C	Total number of deliveries you performed during reporting period: <u>2</u>
D	Total number of licensed midwife students assigned to you during the reporting period: <u>0</u>
E	How many delivered at: Home: <u>2</u> Birthing Ctr: <u>0</u> Hospital: <u>0</u>
F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>
G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u>
H	Number of water births: <u>2</u>
I	Number of mothers requiring sutures: <u>2</u>
3 A	Number of mothers transferred antepartum (for medical reasons): <u>0</u>
B	Number of mothers transferred intrapartum: <u>0</u>
C	Number of mothers transferred postpartum: (medical reasons) <u>0</u>
D	Number of newborn transfers: <u>0</u>
4 A	Number of fetal deaths / stillborn: (midwife delivery only) <u>0</u>
B	Number of fetal deaths / neonatal: (within seven days of birth) <u>0</u>
C	Number of maternal deaths: (please submit separate report) <u>0</u>

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Helen Laura Sinnott Fort License #: MW 270
 Practice Name: _____
 Address: 4822 Fenton Street

 Phone Number: 352-219-7895 Email: hlsin@yahoo.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	0
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Helen Laura Sinnott Fort

Signature: *Helen Laura Sinnott Fort*

Date Signed: July 31, 2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ License #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____
	F	Number of unplanned: Breech: _____ Twins / Multiples: _____
	G	Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____
	H	Number of water births: _____
	I	Number of mothers requiring sutures: _____
3	A	Number of mothers transferred antepartum (for medical reasons): _____
	B	Number of mothers transferred intrapartum: _____
	C	Number of mothers transferred postpartum: (medical reasons) _____
	D	Number of newborn transfers: _____
4	A	Number of fetal deaths / stillborn: (midwife delivery only) _____
	B	Number of fetal deaths / neonatal: (within seven days of birth) _____
	C	Number of maternal deaths: (please submit separate report) _____

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

Signature:  _____

Date Signed: _____

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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Council of Licensed Midwifery
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Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

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JUL 06 2018
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kristin Schwarz License #: 274

Practice Name: _____

Address: 2308 Waccamaw Lane E
Lake Worth, FL 33467

Phone Number: 561-951-0404 Email: Kristin@pino-schwarz.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <input type="checkbox"/>
	B	Total number of maternity clients you accepted for care in the reporting period: <input type="checkbox"/>
	C	Total number of deliveries you performed during reporting period: <input type="checkbox"/>
	D	Total number of licensed midwife students assigned to you during the reporting period: <input type="checkbox"/>
	E	How many delivered at: Home: <input type="checkbox"/> Birthing Ctr: <input type="checkbox"/> Hospital: <input type="checkbox"/> <input type="checkbox"/>
	F	Number of unplanned: Breech: <input type="checkbox"/> Twins / Multiples: <input type="checkbox"/> <input type="checkbox"/>
G	Number of planned VBAC: # of primary VBAC: <input type="checkbox"/> # of subsequent VBAC: <input type="checkbox"/> <input type="checkbox"/>	
H	Number of water births: <input type="checkbox"/>	
I	Number of mothers requiring sutures: <input type="checkbox"/>	
3	A	Number of mothers transferred antepartum (for medical reasons): <input type="checkbox"/>
	B	Number of mothers transferred intrapartum: <input type="checkbox"/>
	C	Number of mothers transferred postpartum: (medical reasons) <input type="checkbox"/>
	D	Number of newborn transfers: <input type="checkbox"/>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <input type="checkbox"/>
	B	Number of fetal deaths / neonatal: (within seven days of birth) <input type="checkbox"/>
	C	Number of maternal deaths: (please submit separate report) <input type="checkbox"/>

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

0

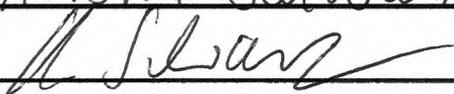
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kristin Schwarz
Signature: 
Date Signed: 07/01/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Muraiha Gizinski (Vaughn) **License #:** 275
Practice Name: Woman's Ways
Address: 209 Cartier Ave. Melbourne, FL. 32901
Phone Number: 321-984-0553 **Email:** MelbourneMidwife@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					6
	B	Total number of maternity clients you accepted for care in the reporting period:					6
	C	Total number of deliveries you performed during reporting period:					3
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	3	Birthing Ctr:	0	Hospital:	3
F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	0	
H	Number of water births:					2	
I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					1
	B	Number of mothers transferred intrapartum:					2
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

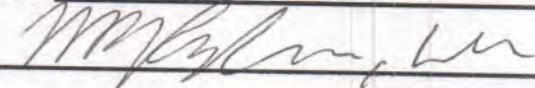
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Muraiha R Gizinski (Vaughn)

Signature: 

Date Signed: 7/31/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Charlie Rae Young License #: MW274
 Practice Name: Barefoot Birth
 Address: 2746 N Florida Ave Tampa FL 33602

Phone Number: 813 5150825 Email: charlie@barefootbirth.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					60
	B	Total number of maternity clients you accepted for care in the reporting period:					50
	C	Total number of deliveries you performed during reporting period:					5
	D	Total number of licensed midwife students assigned to you during the reporting period:					2
	E	How many delivered at:	Home: 5	Birthing Ctr: 0	Hospital: 0		5
F	Number of unplanned:	Breech: 0	Twins / Multiples: 0			0	
G	Number of planned VBAC:	# of primary VBAC: 0	# of subsequent VBAC: 0			0	
H	Number of water births:					1	
I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					7
	B	Number of mothers transferred intrapartum:					2
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/12/17	Post dates	UP	42	NSVD
7/25/17	Breech pres	UP	40	C/S
8/21/17	Post dates	UP	41+5	NSVD
8/22/17	Post dates	UP	41+5	NSVD
11/9/17	Post dates/unstable lie	UP	41+1	NSVD
10/22/17	PPROM, chorio	UP	38+4	NSVD
12/12/17	PPROM, post dates	UP	41+1	NSVD
	PPROM error	UP error		

Total Number of Antepartum Transfers from all sheet (3-A) **7**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7/12/17	fetal intolerance	✓	NO	7#12	NO	NO
6/26/18	MSAF	✓	NO	7#5	NO	NO
7/12/17	error					

Total Intrapartum Transfers from all sheets (3-B) **2**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

N/A

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

N/A

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

0

SECTION IV - DEATHS

N/A

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant) N/A

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Charlie Rae Young
 Signature: 
 Date Signed: 7/14/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov



ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Michelle Isla License #: MW277
 Practice Name: Tree of Life Birth & Gym
 Address: 1010 Arthur Ave Orlando, FL 32804
 Phone Number: 407-878-2757 Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					67
	B	Total number of maternity clients you accepted for care in the reporting period:					67
	C	Total number of deliveries you performed during reporting period:					49
	D	Total number of licensed midwife students assigned to you during the reporting period:					3
	E	How many delivered at:	Home: 21	Birthing Ctr: 28	Hospital: 0		49
F	Number of unplanned:	Breech: 0	Twins / Multiples: 0			0	
G	Number of planned VBAC:	# of primary VBAC: 1	# of subsequent VBAC: 0			1	
H	Number of water births:					20	
I	Number of mothers requiring sutures:					20	
3	A	Number of mothers transferred antepartum (for medical reasons):					13
	B	Number of mothers transferred intrapartum:					9
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
9/5/17	7/18/17 LOW FLUID	UNPL	40	VBAC NSVD
2.	10/7/17 PPRM	UNPL	35	NSVD
3.	12/19/17 Breech	UNPL	40	C/S
4.	1/18/18 Breech & Subseptate uterus	PLAN	39	C/S
5.	3/8/18 Cholestasis	PLAN	30	unknown
6.	3/22/18 PPRM	UNPL	35	NSVD
7.	3/29/18 Breech	UNPL	37	C/S
8.	4/10/18 TWIN pregnancy	UNPL	25	unknown
9.	5/8/18 TWIN pregnancy	UNPL	13	unknown
10.	5/8/18 Placental Abruption	UNPL	25	NSVD
11.	5/13/18 PIH	UNPL	37	C/S
Total Number of Antepartum Transfers from all sheet (3-A)				13

* CONT ON SEPARATE PAGE

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
1.	7/9/17 Chorio	NSVD	NO Chorio	7-3	NO	NO
2.	9/24/17 HTN	C/S	NO		NO	NO
3.	2/7/18 MSAF	VBAC NSVD	NO	8-6	NO	NO
4.	2/18/18 pain mgmt	NSVD	NO		NO	NO
5.	2/26/18 Arrest of dilation	C/S	NO	8-2	NO	NO
6.	4/10/18 pain mgmt	C/S	NO	8-3	NO	NO
7.	6/21/18 pain mgmt	NSVD	Chorio	7-4	NO	NO
8.	6/21/18 Arrest of descent	vacuum assist	NO	7-10	NO	NO
9.	1/17/18 Arrest of dilation	C/S	NO	8-6	NO	NO
Total Intrapartum Transfers from all sheets (3-B)						9

CONT

3-A ANTEPARTUM TRANSFER

<u>DATE</u>	<u>REASON</u>	<u>PL/UNP</u>	<u>GA</u>	<u>OUTCOME</u>
5/30/18	PTL	UNPL	35	NSVD
4/14/18	TWIN PREGNANCY	UNPL	12	unknown

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Michelle Isla

Signature: Michelle Isla

Date Signed: 7/30/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kathryn Miller License #: MW278
 Practice Name: Wonderfully Made Midwifery Care
 Address: 7646 Bulls Head DR
Wesley Chapel FL 33545
 Phone Number: 8135061823 Email: katie@wonderfullymademidwifery.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 23
	B	Total number of maternity clients you accepted for care in the reporting period: 23
	C	Total number of deliveries you performed during reporting period: 17 18
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 17 18 Birthing Ctr: — Hospital: — 18 17
	F	Number of unplanned: Breech: — Twins / Multiples: —
	G	Number of planned VBAC: # of primary VBAC: 1 # of subsequent VBAC: 2 3
	H	Number of water births: 10
	I	Number of mothers requiring sutures: 1
3	A	Number of mothers transferred antepartum (for medical reasons): 5
	B	Number of mothers transferred intrapartum: 3
	C	Number of mothers transferred postpartum: (medical reasons) 2
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
8/5/17	preeclampsia	Unplanned	39	C/S
10/9/17	preterm labor @ 32 weeks	Unplanned	32	NSVD
11/8/17	cholestasis	Unplanned	39	NSVD
5/21/18	placental abruption	Unplanned	41	C/S
6/7/18	PROM with no labor	Unplanned	40	NSVD

Total Number of Antepartum Transfers from all sheet (3-A) **5**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? if yes, reason and # of days	Neonatal Death?
10/14/17	FTP	NSVD	NONE	9.9	NO	NO
10/29/17	Fetal Distress	NSVD	NONE	7.10	NO	NO
2/4/18	Thick MSAF	NSVD	NONE	?	NO	NO

Total Intrapartum Transfers from all sheets (3-B) **3**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
9/30/17	Hematoma	4	Surgery to remove hematoma, doing well at discharge
10/19/17	hemorrhage	1	monitor bleeding, ultrasound, doing well at discharge
Total Number of Postpartum Transfers from all sheets (3-C)			2

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
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			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

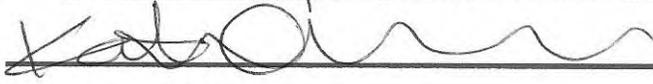
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kathryn Miller
Signature: 
Date Signed: 7/15/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Cathy Celeste McLeod License #: MW 279
 Practice Name: Celestial Midwifery
 Address: 1308 Olympia Park Circle
Ocoee, FL 34761
 Phone Number: 407-923-6874 Email: celeste@celestialmidwifery.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					16	
	B	Total number of maternity clients you accepted for care in the reporting period:					16	
	C	Total number of deliveries you performed during reporting period:					10 11	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	11	Birthing Ctr:	0	Hospital:	0	11
	F	Number of unplanned: Breech:	0	Twins / Multiples:	0			0
	G	Number of planned VBAC:	# of primary VBAC:	2	# of subsequent VBAC:	0		2
	H	Number of water births:	2					2
	I	Number of mothers requiring sutures:					1	
3	A	Number of mothers transferred antepartum (for medical reasons):					3	
	B	Number of mothers transferred intrapartum:					1	
	C	Number of mothers transferred postpartum: (medical reasons)					1	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
10/3/17	Low BPP score	unplanned	41	C/S good
2/7/18	Low BPP score	unplanned	34	C/S good
2/26/18	Post dates induction	unplanned	42	C/S good
3/5/18	uterine rupture R/O	unplanned	40	C/S - good

Total Number of Antepartum Transfers from all sheet (3-A) **4**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
3/5	fetal distress	C/S	uterine Rupture	8# ^{2oz}	NO	NO
8/5	failure to progress maternal exhaustion	C/S	failure to progress	8# ^{6oz}	NO	NO

Total Intrapartum Transfers from all sheets (3-B) **2**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
7/3	3 rd degree laceration	2	good / good
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Cathy Celeste McLeod, LM
 Signature: Cathy Celeste McLeod, LM
 Date Signed: 7/31/2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Shannon Evans **License #:** 281
Practice Name: Beautiful Beginnings Midwifery and Birth Center
Address: 3150 N. Wickham Rd. #1
 Melbourne, FL 32934
Phone Number: 954-668-9946 **Email:** midwifeshannonevans@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number								Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:						23
	B	Total number of maternity clients you accepted for care in the reporting period:						23
	C	Total number of deliveries you performed during reporting period:						13
	D	Total number of licensed midwife students assigned to you during the reporting period:						1
	E	How many delivered at: Home:	7	Birthing Ctr:	6	Hospital:	0	13
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC: # of primary VBAC:	0	# of subsequent VBAC:	0			0
	H	Number of water births:						7
	I	Number of mothers requiring sutures:						6
3	A	Number of mothers transferred antepartum (for medical reasons):						1
	B	Number of mothers transferred intrapartum:						2
	C	Number of mothers transferred postpartum: (medical reasons)						0
	D	Number of newborn transfers:						0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)						0
	B	Number of fetal deaths / neonatal: (within seven days of birth)						0
	C	Number of maternal deaths: (please submit separate report)						0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
1/27/18	PPROM	unplanned	36	C/S

Total Number of Antepartum Transfers from all sheet (3-A) 1

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
10/1/17	FTP 2nd stage	VAVD	3rd degree laceration	6lb13oz	No	No
2/20/18	FTP 1st stage, prolonged ROM	NSVD	None	6lb3oz	No	No

Total Intrapartum Transfers from all sheets (3-B) 2

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
N/A			
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
N/A			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
N/A						
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
N/A				
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Shannon Evans

Signature: 

Date Signed: 7/26/18

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Bree Moses License #: MW282
 Practice Name: UF HEALTH BIRTH CENTER
 Address: JACKSONVILLE, FL 32205
JACKSONVILLE, FL 32205
 Phone Number: (904)535-1803 Email: breemoses@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					18	
	B	Total number of maternity clients you accepted for care in the reporting period:					18	
	C	Total number of deliveries you performed during reporting period:					12	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	0	Birthing Ctr:	12	Hospital:	0	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:					8	
	I	Number of mothers requiring sutures:					3	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					0	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
Total Number of Antepartum Transfers from all sheet (3-A)				

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Bree Moses

Signature: _____

Date Signed: 8/30/18

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Elizabeth Charron **License #:** MW283
Practice Name: Maiden To Mother Midwifery
Address: 11236 SW 56 Circle, Cooper City, FL 33330
Phone Number: 954-404-3502 **Email:** Lizziecharron@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					74
	B	Total number of maternity clients you accepted for care in the reporting period:					74
	C	Total number of deliveries you performed during reporting period:					31
	D	Total number of licensed midwife students assigned to you during the reporting period:					1
	E	How many delivered at: Home:	14	Birthing Ctr:	17	Hospital:	31
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		0
	G	Number of planned VBAC: 0	# of primary VBAC:	0	# of subsequent VBAC:	0	0
	H	Number of water births:					11
	I	Number of mothers requiring sutures:					3
3	A	Number of mothers transferred antepartum (for medical reasons):					13
	B	Number of mothers transferred intrapartum:					4
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
10/27/17	Planned hospital birth	Planned	40	NSVD
12/16/17	Pain Relief	Unplanned	41	C/S
1/12/18	Post Dates	Planned	42	NSVD
1/26/18.	Non-Payment	Unplanned	36	C/S
10/3/17	Changed provider	Planned	26	Unknown
3/28/18	PIH	Unplanned	40	NSVD
3/9/18	Non-Compliant	Unplanned	39	NSVD
2/15/18	Changed provider	Planned	21	Unknown
5/8/18	Changed provider	Planned	13	Unknown
6/28/18	Miscarriage	Unplanned	10	D&C
11/11/17	Pain relief	Unplanned	40	NSVD
Total Number of Antepartum Transfers from all sheet (3-A)				13

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
2/22/18	Surprise Breech	C/S.	No.	7lbs 10oz.	No.	No
6/6/18.	Pain management	NSVD	No	8lbs 9oz.	No	No
10/29/18	FTP	C/S	No	7lbs 15oz.	No	No
11/7/18	FTP	C/S	No	7lbs 4oz.	No	No
Total Intrapartum Transfers from all sheets (3-B)						4

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Elizabeth Charron

Signature: 

Date Signed: 7/19/18

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3266
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Melissa Marks License #: 285
 Practice Name: Midwife Melissa Marks, LLC
 Address: 101 Palmer St.
St. Augustine, FL 32084
 Phone Number: 904-547-0760 Email: midwifemelissamarks@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	1
	B	Total number of maternity clients you accepted for care in the reporting period:	1
	C	Total number of deliveries you performed during reporting period:	0
	D	Total number of licensed midwife students assigned to you during the reporting period:	0
	E	How many delivered at: Home: 0 Birthing Ctr: 0 Hospital: 0	0
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0	0
	G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0	0
	H	Number of water births:	0
	I	Number of mothers requiring sutures:	0
3	A	Number of mothers transferred antepartum (for medical reasons):	0
	B	Number of mothers transferred intrapartum:	0
	C	Number of mothers transferred postpartum: (medical reasons)	0
	D	Number of newborn transfers:	0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	0
	B	Number of fetal deaths / neonatal: (within seven days of birth)	0
	C	Number of maternal deaths: (please submit separate report)	0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	N/A			

Total Number of Antepartum Transfers from all sheet (3-A) 0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
	N/A					

Total Intrapartum Transfers from all sheets (3-B) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A				

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	N/A	
Total Number of Maternal Deaths (4-C)		0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Melissa-Marie Marks
Signature: Melisse Marks, LM, CPM
Date Signed: 07/31/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov



ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Audrey Luck License #: MW286
 Practice Name: Birthways Family Birth Center
 Address: 4222 McIntosh Lane Rd
Sarasota FL 34235
 Phone Number: (386) 898-1257 Email: aluck@midwiferyschool.org

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	51
	B Total number of maternity clients you accepted for care in the reporting period:	48
	C Total number of deliveries you performed during reporting period:	39
	D Total number of licensed midwife students assigned to you during the reporting period:	2
	E How many delivered at: Home: <u>3</u> Birthing Ctr: <u>32</u> Hospital: <input checked="" type="checkbox"/>	35
	F Number of unplanned: Breech: <input checked="" type="checkbox"/> Twins / Multiples: <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	G Number of planned VBAC: # of primary VBAC: <input checked="" type="checkbox"/> # of subsequent VBAC: <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	H Number of water births:	15
	I Number of mothers requiring sutures:	7
3	A Number of mothers transferred antepartum (for medical reasons):	3
	B Number of mothers transferred intrapartum:	5
	C Number of mothers transferred postpartum: (medical reasons)	ERROR 43
	D Number of newborn transfers:	<input checked="" type="checkbox"/>
4	A Number of fetal deaths / stillborn: (midwife delivery only)	<input checked="" type="checkbox"/>
	B Number of fetal deaths / neonatal: (within seven days of birth)	<input checked="" type="checkbox"/>
	C Number of maternal deaths: (please submit separate report)	<input checked="" type="checkbox"/>

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	PIH with possible Pre-E	unplanned		NSVD
	PIH with possible Pre-E	unplanned		C/S
	Risk out of COH delivery for previous low APGARs and LGA w/ shoulder dystocia	planned		NSVD

Total Number of Antepartum Transfers from all sheet (3-A) **3**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
9/30/17	Failure to progress	vaginal	No		No	No
11/03/17	SRM 12 hrs and no active labor	vaginal	No		No	No
1/27/17	Arrest in dilation and descent w/ ineffective UC	C/S	No		No	No
4/21/18	Long labor > 24 hrs Epidural, OP pres	C/S	No		No	No
5/3/18	Long labor > 24 hrs Epidural	vaginal	Infected 2nd laceration requiring repeat repair		No	No

Total Intrapartum Transfers from all sheets (3-B) **5**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
7/20/17	immediate PPH ≥ 1000 ml	2 days	2 units of blood transfusion stable @ discharge
3/23/18	PPH (mild) EBL ≥ 499 ml	6 hrs	Clots expressed from cervix stable @ discharge
5/17/18	Active bleed w/ retained placenta	24 hrs	Placenta delivered @ hospital stable @ discharge
Total Number of Postpartum Transfers from all sheets (3-C)			3

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

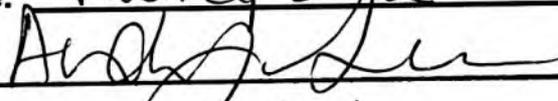
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Audrey Lvgle
Signature: 
Date Signed: 8/6/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Mary Surprenant **License #:** MW287
Practice Name: Inspiration Family Birth Center
Address: 434 Grove Avenue Winter Park, FL 32789
Phone Number: 4076445567 **Email:** mary@inspirationmidwifery.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number								Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:						57
	B	Total number of maternity clients you accepted for care in the reporting period:						57
	C	Total number of deliveries you performed during reporting period:						100
	D	Total number of licensed midwife students assigned to you during the reporting period:						2
	E	How many delivered at: Home:	27	Birthing Ctr:	73	Hospital:	0	100
	F	Number of unplanned: Breech:	3	Twins / Multiples	0			
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	1		1
	H	Number of water births:						71
	I	Number of mothers requiring sutures:						14
3	A	Number of mothers transferred antepartum (for medical reasons):						5
	B	Number of mothers transferred intrapartum:						7
	C	Number of mothers transferred postpartum: (medical reasons)						1
	D	Number of newborn transfers:						0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)						0
	B	Number of fetal deaths / neonatal: (within seven days of birth)						0
	C	Number of maternal deaths: (please submit separate report)						0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
9/10/2017	Pre-Eclampsia	UnPlanned	35	vaginal
12/26/2017	Pre term labor	UnPlanned	30	vaginal
1/1/2018	Low Hbg	UnPlanned	40	
4/2/2018	Placental Abruption	UnPlanned	22	
6/28/2018	Fetal Demise	UnPlanned	24	
Total Number of Antepartum Transfers from all sheet (3-A)				5

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7/20/17	Pain relief	C/S	Meconium	unk	NO	No
8/13/17	Non Reassuring FHR	C/S		6 / 6	NO	No
8/26/17	Failure to Progress 2nd Stage	C/S /			NO	No
11/20/17	FTP, Pain Management /				NO	No
5/30/18	PROM no CTX /				NO	No
6/19/18	FTP	C/S			NO	No
6/19/18	FTP	C/S			NO	No
Total Intrapartum Transfers from all sheets (3-B)						7

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
7/10/2017	Retained Placenta	0	D&C of Placenta/Stable
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	No Events		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	No Events					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	No events			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	N/A
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Mary Surprenant

Signature: *Mary Surprenant*

Date Signed: 7/31/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Shea Cintron License #: MW288
 Practice Name: Birth Collective of Jacksonville
 Address: 1919 Atlantic blvd
Jacksonville, FL 32207
 Phone Number: 904.633.3333 Email: Shea@bcofjax.com
Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 110
	B	Total number of maternity clients you accepted for care in the reporting period: 110
	C	Total number of deliveries you performed during reporting period: 69
	D	Total number of licensed midwife students assigned to you during the reporting period: 2
	E	How many delivered at: Home: 59 Birthing Ctr: 10 Hospital: 0
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0
	G	Number of planned VBAC: 2 # of primary VBAC: 1 # of subsequent VBAC: 3
	H	Number of water births: 50
	I	Number of mothers requiring sutures: 0
3	A	Number of mothers transferred antepartum (for medical reasons): 1
	B	Number of mothers transferred intrapartum: 1
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

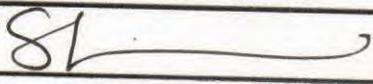
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Shea Cintron
Signature: 
Date Signed: 7.20.2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jessica Willoughby **License #:** MW289
Practice Name: The Birth Center of St. Pete
Address: 1405 Dr. Martin Luther King Jr. St. N, Saint. Petersburg, FL 33704
Phone Number: 727895-2300 **Email:** office@bcfstpete.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					96	
	B	Total number of maternity clients you accepted for care in the reporting period:					96	
	C	Total number of deliveries you performed during reporting period:					45	
	D	Total number of licensed midwife students assigned to you during the reporting period:					3	
	E	How many delivered at: Home:	21	Birthing Ctr:	24	Hospital:	0	45
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC: # of primary VBAC:	0	# of subsequent VBAC: VBA2C	1			1
	H	Number of water births:					26	
	I	Number of mothers requiring sutures:					15	
3	A	Number of mothers transferred antepartum (for medical reasons):					3	
	B	Number of mothers transferred intrapartum:					9	
	C	Number of mothers transferred postpartum: (medical reasons)					1	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7-17-17	Non Vertex	Planned	41	C/S
8-16-17	Low Fluid Postdates	Unplanned	41	C/S
8-24-17	Low Fluid	Unplanned	41	Forceps
Total Number of Antepartum Transfers from all sheet (3-A)				3

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7-21	Failure to descend	C/S	None	3530g	Yes TTN	NO
8-16	MSAF	VBAC	None	3373g	NO	NO
8-30	Non-reassuring FHT	NSVD	None	4570g	NO	NO
2-11	Maternal Req Pain Med	NSVD	None	3450g	No	NO
3-26	PROM	NSVD	None	4270g	NO	NO
4-22	FTP	NSVD	None	3840g	NO	NO
5-9	PPROM	NSVD	TTN/Jaundice	2470g	Yes Pretern/hyperbiliruminemia	NO
5-18	FTP	C/S	None	4210g	NO	NO
6-1	Maternal Req Pain Med	NSVD	None	3316g	Yes TTN r/o RDS	NO
Total Intrapartum Transfers from all sheets (3-B)						9

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
2-11	4th degree tear	1	Repaired in OR
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Jessica Willoughby

Signature: 

Date Signed: 07 / 30 / 2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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 JUL 30 2018
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Tania Mondesir License #: MW 290
 Practice Name: Miami Maternity Center
 Address: 140 N.E. 119 St. Miami, Fla. 33161

Phone Number: (305) 754-2229 Email: Tania_mondesir@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					59	
	B	Total number of maternity clients you accepted for care in the reporting period:					6	
	C	Total number of deliveries you performed during reporting period:					29	
	D	Total number of licensed midwife students assigned to you during the reporting period:						
	E	How many delivered at: Home:	1	Birthing Ctr:	29	Hospital:	0	30
	F	Number of unplanned: Breech:	0	Twins / Multiples:	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:					17	
	I	Number of mothers requiring sutures:					18	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					5	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

0
0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Tania Mondesir.
Signature: Tania Mondesir
Date Signed: 07-25-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

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Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov



ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Cheryl Moore License #: MW291
 Practice Name: Circle of Life
 Address: 900 Wellington Dr Clearwater FL 33764
 Phone Number: 813.426.2397 Email: catchbabies@aol.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					36	
	B	Total number of maternity clients you accepted for care in the reporting period:					36	
	C	Total number of deliveries you performed during reporting period:					29 ²⁹	
	D	Total number of licensed midwife students assigned to you during the reporting period:					1	
	E	How many delivered at: Home:	21	Birthing Ctr:	8	Hospital:	∅	29
	F	Number of unplanned: Breech:	∅	Twins / Multiples	∅			∅
	G	Number of planned VBAC:	# of primary VBAC:	2	# of subsequent VBAC:	∅		2
	H	Number of water births:					10	
	I	Number of mothers requiring sutures:					2	
3	A	Number of mothers transferred antepartum (for medical reasons):					3	
	B	Number of mothers transferred intrapartum:					4	
	C	Number of mothers transferred postpartum: (medical reasons)					1	
	D	Number of newborn transfers:					∅	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					∅	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					∅	
	C	Number of maternal deaths: (please submit separate report)					∅	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
12/19/17	Twin Pregnancy	Planned	10wks	C/S
Total Number of Antepartum Transfers from all sheet (3-A)				1

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? if yes, reason and # of days	Neonatal Death?
11/9/17	FTP	NSVD	None	7.0	NA	NA
11/7/17	FTP P/Prom	C/S	None	8.2	NA	NA
2/21/18	Fetal Distress	NSVD	None	7.6	NA	NA
6/8/18	FTP	NSVD	None	8.8	NA	NA
Total Intrapartum Transfers from all sheets (3-B)						4

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
11/27/17	Repair of possible 3" Tear	0	Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
7/1/17	Jaundice	6.3	10	NA	discharge 3 days
5/2/18	Jaundice	7.8	10	NA	discharge 4 days

Total Newborn Transfers from all sheets(3-D) 2

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NA					

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Cheryl Moore LM
Signature: Cheryl Moore LM
Date Signed: 7/18/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Sandra Parisi License #: MW 292
 Practice Name: _____
 Address: 12963 S. Indian River Dr
Jensen Beach, FL 34957
 Phone Number: 772-834-0123 Email: midwifeparisi@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					14
	B	Total number of maternity clients you accepted for care in the reporting period:					1
	C	Total number of deliveries you performed during reporting period:					1
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
E	How many delivered at: Home:	1	Birthing Ctr:	0	Hospital:	0	1
F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	0	
H	Number of water births:					0	
I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)



(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)



SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)



(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: SANDRA PARISI
 Signature: *Sandra Parisi*
 Date Signed: 9/4/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Karla Holt License #: MW293
 Practice Name: Labor of Love Birth Center
 Address: 106 Myrtle Ridge Rd
Lutz, FL 33549
 Phone Number: (813) 949-1185 Email: laboroflovekarla@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					62
	B	Total number of maternity clients you accepted for care in the reporting period:					62
	C	Total number of deliveries you performed during reporting period:					46
	D	Total number of licensed midwife students assigned to you during the reporting period:					3
	E	How many delivered at: Home:	8	Birthing Ctr:	38	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	1	1
	H	Number of water births:					26
	I	Number of mothers requiring sutures:					12
3	A	Number of mothers transferred antepartum (for medical reasons):					29
	B	Number of mothers transferred intrapartum:					45
	C	Number of mothers transferred postpartum: (medical reasons)					4
	D	Number of newborn transfers:					5
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0
	C	Number of maternal deaths: (please submit separate report)					0

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(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
10/14/17	3rd Degree Laceration Repair	W/K	Normal Recovery
10/22/17	3rd Degree Laceration Repair	<1	Normal Recovery
1/29/18	Precipitous Birth / called from Ambulance	1	Normal Recovery
2/17/18	3rd Degree Laceration Repair	1	Normal Recovery
8/15/17	Maternal Preference to transfer baby	1	Normal Recovery

Total Number of Postpartum Transfers from all sheets (3-C) 4

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
8/15/17	Low Birth Weight	5lb 10oz	U/K	NO	Discharged <24 hrs
10/14/17	Cranial Edema/Hematoma	11lb 6oz	7/9	YES, W/K	Hematoma Resolved
1/29/18	Precipitous Birth / called from Ambulance	10lb 12oz	U/K	NO	Discharged <24 hrs
2/2/18	Lethargic Newborn	5lb 10oz	9/10	YES, 2	IV hydration, Discharged 2 days
02/17/18	Neonatal Exam/Clavicle X-Ray	8lb 5oz	2/10	NO	Healthy/intact clavicles

Total Newborn Transfers from all sheets(3-D) 5

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Karla Holt, LM, CPM, CLC
Signature: 
Date: 7/12/18



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Angela J Fennell License #: MW 294
 Practice Name: Lake City Birth, LLC
 Address: 5113 256th Street
O'Brien, FL 32071

Phone Number: (386) 288-0698 Email: angie@lakecityhomebirth.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					31
	B	Total number of maternity clients you accepted for care in the reporting period:					31
	C	Total number of deliveries you performed during reporting period:					26
	D	Total number of licensed midwife students assigned to you during the reporting period:					
	E	How many delivered at: Home:	26	Birthing Ctr:	0	Hospital:	0
F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
G	Number of planned VBAC:	# of primary VBAC:	2	# of subsequent VBAC:	3		5
H	Number of water births:					17	
I	Number of mothers requiring sutures:					3	
3	A	Number of mothers transferred antepartum (for medical reasons):					1
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Angela J. Fennell

Signature: Angela Fennell, MD

Date Signed: 7/3/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Laura Nathan **License #:** MW295
Practice Name: Inspiration Family Birth Center
Address: 434 Grove Avenue Winter Park, FL 32789
Phone Number: 4076445567 **Email:** info@loveybirth.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					53
	B	Total number of maternity clients you accepted for care in the reporting period:					52
	C	Total number of deliveries you performed during reporting period:					9
	D	Total number of licensed midwife students assigned to you during the reporting period:					2
	E	How many delivered at: Home:	1	Birthing Ctr:	8	Hospital:	9
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC: # of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:					6
	I	Number of mothers requiring sutures:					4
3	A	Number of mothers transferred antepartum (for medical reasons):					10
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					1
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
7/6/2017	Maternal bleeding	1	No transfusion, discharged Stable
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	No Events		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS**(4-A) STILLBIRTH (midwife delivered only)**

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	No Events					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	No events			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Laura Nathan

Signature: *Laura Nathan*

Date Signed: 07/31/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

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Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Emily Hovet License #: MW296
 Practice Name: Labor of Love Birth Center
 Address: 106 Myrtle Ridge Rd
Lt 12, FL 33549
 Phone Number: 813 949 1185 Email: Emilyhovet@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care): 39
	B	Total number of maternity clients you accepted for care in the reporting period: 39
	C	Total number of deliveries you performed during reporting period: 36
	D	Total number of licensed midwife students assigned to you during the reporting period: 3
	E	How many delivered at: Home: 6 Birthing Ctr: 30 Hospital: 0
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0
	G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 1
	H	Number of water births: 17
	I	Number of mothers requiring sutures: 10
3	A	Number of mothers transferred antepartum (for medical reasons): 9
	B	Number of mothers transferred intrapartum: 54
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within 7 days of life) 0
	C	Number of maternal deaths: (please submit separate report) 0

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SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
8/17/17	breech	planned	40 ³	CIS
10/10/17	PPROM	planned	34 ⁶	NSVD
11/17/17	breech	planned	38 ²	CIS
11/26/17	PPROM	planned	32 ⁴	NSVD
12/14/17	breech	planned	37 ¹	CIS
1/5/18	placenta previa	planned	33 ¹	CIS
2/5/18	pre-eclampsia	planned	39 ³	NSVD
5/24/18	Lack of FIT / fetal demise	planned	30 ²	NSVD
6/1/18	PTL	planned	24 ³	NSVD
Total Number of Antepartum Transfers from all sheet (3-A)				9

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
9/23/17	PROM / FTP	NSVD	NO	9#6oz	NO	NO
9/10/17	PROM / FTP	NSVD	NO	6#6oz	NO	NO
10/31/17	2/8 BPP - 10L	CIS	punctured bladder	8#7oz	NO	NO
3/10/18	PROM / FTP	CIS	NO	7#3oz	NO	NO
Total Intrapartum Transfers from all sheets (3-B)						4

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			ϕ

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					ϕ

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						ϕ

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Emily Horet, LM, CPM

Signature: E. Horet, LM, CPM

Date: 7/1/18



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Rachel Powers **License #:** MW297
Practice Name: Beautiful Beginnings Midwifery & Birth Center
Address: 3150 North Wickham Rd Suite1
 Melbourne, FL 32935
Phone Number: 321-775-3334 **Email:** beautifulbeginningsmidwifery@gmail.com

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					36	
	B	Total number of maternity clients you accepted for care in the reporting period:					36	
	C	Total number of deliveries you performed during reporting period:					16	
	D	Total number of licensed midwife students assigned to you during the reporting period:					2	
	E	How many delivered at: Home:	14	Birthing Ctr:	2	Hospital:	0	16
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	2		2
	H	Number of water births:					5	
	I	Number of mothers requiring sutures:					5	
3	A	Number of mothers transferred antepartum (for medical reasons):					3	
	B	Number of mothers transferred intrapartum:					1	
	C	Number of mothers transferred postpartum: (medical reasons)					2	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
9/1/17	3rd degree laceration	<1	repaired & discharged to home
9/8/17	posterior cervical laceration	<1	repaired & discharged to home
Total Number of Postpartum Transfers from all sheets (3-C)			2

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Rachel Powers, LM, CPM

Signature: *Rachel Powers, LM, CPM*

Date Signed: 7/29/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ License #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____
	F	Number of unplanned: Breech: _____ Twins / Multiples: _____
	G	Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____
	H	Number of water births:
	I	Number of mothers requiring sutures:
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

Signature: _____

Date Signed: _____

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: BRENDA FRANCIS, LM,CPM License #: MW299
 Practice Name: NU LIFE MIDWIFERY SERVICES
 Address: 1670 Pleasant Hill Rd. Kissimmee Fl, 34746
 Phone Number: (352)598-4703 Email: nulifemidwife@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					26
	B	Total number of maternity clients you accepted for care in the reporting period:					26
	C	Total number of deliveries you performed during reporting period:					11
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	11	Birthing Ctr:	0	Hospital:	5
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC: # of primary VBAC:	1	# of subsequent VBAC:	0		
	H	Number of water births:					4
	I	Number of mothers requiring sutures:					4
3	A	Number of mothers transferred antepartum (for medical reasons):					5
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

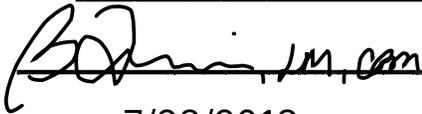
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Brenda Francis, LM, CPM

Signature: 

Date Signed: 7/28/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov



ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: YOFFE ALARCON License #: MV300
 Practice Name: YOFFE ALARCON Health Services
 Address: - 1447 PLUNKET ST HOLLYWOOD FL
- SANTAS MEDICAL CENTER MIAMI LAKES FL
 Phone Number: 786 4260880 Email: YOFFEALARCON@YAHOO.COM

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <u>33</u>
	B	Total number of maternity clients you accepted for care in the reporting period: <u>22</u>
	C	Total number of deliveries you performed during reporting period: <u>3</u>
	D	Total number of licensed midwife students assigned to you during the reporting period: <u>0</u>
	E	How many delivered at: Home: <u>0</u> Birthing Ctr: <u>0</u> Hospital: <u>3</u> <u>3</u>
	F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u> <u>0</u>
	G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u> <u>0</u>
	H	Number of water births: <u>0</u>
	I	Number of mothers requiring sutures: <u>0</u>
3	A	Number of mothers transferred antepartum (for medical reasons): <u>0</u>
	B	Number of mothers transferred intrapartum: <u>0</u>
	C	Number of mothers transferred postpartum: (medical reasons) <u>0</u>
	D	Number of newborn transfers: <u>0</u>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <u>0</u>
	B	Number of fetal deaths / neonatal: (within seven days of birth) <u>0</u>
	C	Number of maternal deaths: (please submit separate report) <u>0</u>

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

YOFRE ALVARAN B

Signature: _____

YOFRE ALVARAN B

Date Signed: _____

JULY 29th, 2018.

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
 MQA.Midwifery@FIHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: MIGUEL ANASTASIO MARTIN License #: MW-301
 Practice Name: ALBERTO DOMINGUEZ-BALI
 Address: 777 EAST 25ST SUITE 203, HIALEAH FLORIDA 33013
 Phone Number: 305-693-3535 Email: LOZADACASTROMARJORIE@GMAIL.COM

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					322
	B	Total number of maternity clients you accepted for care in the reporting period:					322
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:	0
	F	Number of unplanned:	Breech:	Twins / Multiples			0
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		0
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0
	C	Number of maternal deaths: (please submit separate report)					

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A				

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			

Total Number of Fetal/Neonatal Deaths (4-B)

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Printed Name: MIGUEL ANASTASIO MARTIN

Signature: 

Date Signed: 07/19/2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
 MQA.Midwifery@FIHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
 MQA.Midwifery@FIHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Mercedes Escalante **License #:** MW 302
Practice Name: Special Delivery Health Center, LLC
Address: 123 North Krome Ave Suite 101
 Homestead, FL 33032
Phone Number: 305-224-9333 **Email:** mescalante@specialdeliveryhc.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	2
	B	Total number of maternity clients you accepted for care in the reporting period:	2
	C	Total number of deliveries you performed during reporting period:	0
	D	Total number of licensed midwife students assigned to you during the reporting period:	0
	E	How many delivered at: Home: <input type="text"/> Birthing Ctr: <input type="text"/> Hospital: <input type="text"/>	0
	F	Number of unplanned: Breech: <input type="text"/> Twins / Multiples: <input type="text"/>	0
	G	Number of planned VBAC: <input type="text"/> # of primary VBAC: <input type="text"/> # of subsequent VBAC: <input type="text"/>	0
	H	Number of water births: <input type="text"/>	0
	I	Number of mothers requiring sutures: <input type="text"/>	0
3	A	Number of mothers transferred antepartum (for medical reasons):	0
	B	Number of mothers transferred intrapartum:	0
	C	Number of mothers transferred postpartum: (medical reasons)	0
	D	Number of newborn transfers:	0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	0
	B	Number of fetal deaths / neonatal: (within 7 days of life)	0
	C	Number of maternal deaths: (please submit separate report)	0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A				
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

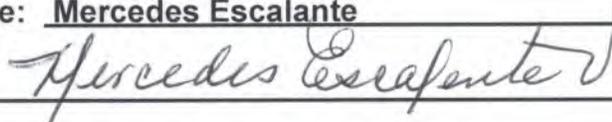
Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Printed Name: Mercedes Escalante

Signature: 

Date Signed: July 18, 2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FIHealth.gov



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Amy McKinnell License #: MW303

Practice Name: nta

Address: 8010 Hilltop St. Longmont, CO 80504

Phone Number: 561-287-0102 Email: vegeamy78@aol.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <input type="checkbox"/>
	B	Total number of maternity clients you accepted for care in the reporting period: <input type="checkbox"/>
	C	Total number of deliveries you performed during reporting period: <input type="checkbox"/>
	D	Total number of licensed midwife students assigned to you during the reporting period: <input type="checkbox"/>
	E	How many delivered at: Home: <input type="checkbox"/> Birthing Ctr: <input type="checkbox"/> Hospital: <input type="checkbox"/>
F	Number of unplanned: Breech: <input type="checkbox"/> Twins / Multiples: <input type="checkbox"/>	
G	Number of planned VBAC: <input type="checkbox"/> # of primary VBAC: <input type="checkbox"/> # of subsequent VBAC: <input type="checkbox"/>	
H	Number of water births: <input type="checkbox"/>	
I	Number of mothers requiring sutures: <input type="checkbox"/>	
3	A	Number of mothers transferred antepartum (for medical reasons): <input type="checkbox"/>
	B	Number of mothers transferred intrapartum: <input type="checkbox"/>
	C	Number of mothers transferred postpartum: (medical reasons) <input type="checkbox"/>
	D	Number of newborn transfers: <input type="checkbox"/>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <input type="checkbox"/>
	B	Number of fetal deaths / neonatal: (within seven days of birth) <input type="checkbox"/>
	C	Number of maternal deaths: (please submit separate report) <input type="checkbox"/>

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	none			

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
	none					

Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	none		

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	none		/		

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	none					

Total Number of Fetal Death/Stillborn (4-A)

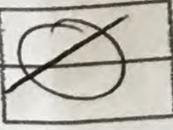
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	none			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)



I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Amy McKinnell

Signature: Amy McKinnell

Date Signed: 7/30/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jackie Borges License #: MW304
 Practice Name: Family Birth Center of Naples
 Address: 2930 Immokalee Rd, Ste 2
Naples, FL 34110
 Phone Number: 239 554 0400 Email: fbcnaples@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number		Total(s)	
2	A	Total number of Initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 23	
	B	Total number of maternity clients you accepted for care in the reporting period: 23	
	C	Total number of deliveries you performed during reporting period: 18	
	D	Total number of licensed midwife students assigned to you during the reporting period: 0	
	E	How many delivered at: Home: 1 Birthing Ctr: 17 Hospital: 0	
F	Number of unplanned: Breech: 0	Twins / Multiples: 0	
	G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0	
H	Number of water births: 7		
	I		Number of mothers requiring sutures: 1
	3		A
B	Number of mothers transferred intrapartum: 5		
	C		Number of mothers transferred postpartum: (medical reasons) 0
	D		Number of newborn transfers: 0
	4		A
B	Number of fetal deaths / neonatal: (within seven days of birth) 0		
	C		Number of maternal deaths: (please submit separate report) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Jacqueline R Burgess LM
 Signature: *Jacqueline Burgess*
 Date Signed: 4-11-18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bln #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: AGATA NELSON License #: MW 305
 Practice Name: _____
 Address: 1770 Victoria Chase Ct
Orange Park FL 32003
 Phone Number: 904-748-5186 Email: agatanelson1027@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0	
	B	Total number of maternity clients you accepted for care in the reporting period:					0	
	C	Total number of deliveries you performed during reporting period:					0	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at:	Home:	0	Birthing Ctr:	0	Hospital:	0
F	Number of unplanned:	Breech:	0	Twins / Multiples	0			0
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0			0
H	Number of water births:						0	
I	Number of mothers requiring sutures:						0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					0	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

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 JUL 11 2018
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(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)				
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: AGATA NELSON

Signature: *Agata Nelson*

Date Signed: 7-2-2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Samantha Crickmore License #: MW 306
 Practice Name: First Coast Midwifery Services
 Address: 7117 Blache Ct Jacksonville, FL 32210
7117 Blache Ct Jacksonville, FL 32210
 Phone Number: (904) 990-3619 Email: samcrickmore@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):	91
	B	Total number of maternity clients you accepted for care in the reporting period:	89
	C	Total number of deliveries you performed during reporting period:	23
	D	Total number of licensed midwife students assigned to you during the reporting period:	2
	E	How many delivered at: Home: 23 Birthing Ctr: 0 Hospital: 1	24
F	Number of unplanned: Breech: 0 Twins / Multiples: 0	0	
G	Number of planned VBAC: # of primary VBAC: 3 # of subsequent VBAC: 2	5	
H	Number of water births:	17	
I	Number of mothers requiring sutures:	7	
3	A	Number of mothers transferred antepartum (for medical reasons):	4
	B	Number of mothers transferred intrapartum:	5
	C	Number of mothers transferred postpartum: (medical reasons)	0
	D	Number of newborn transfers:	0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	0
	B	Number of fetal deaths / neonatal: (within 7 days of life)	0
	C	Number of maternal deaths: (please submit separate report)	0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
12/24/17	Preterm labor/birth	Unplanned	34	NSVD
5/18/18	Postdates	Planned	42	NSVD
5/12/18	Breech	Planned	39	C/S
3/9/18	Hyperemesis Gravidum	Planned	9	Not Delivered
Total Number of Antepartum Transfers from all sheet (3-A)				4

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
11/5/17	Asynclitic/FTP	NSVD	No	8.0	No	No
3/14/18	Pain relief	C/S	No	10.4	No	No
3/20/18	S/S of infection	NSVD	No	7.9	No	No
4/28/18	Pain relief	C/S	No	7.12	No	No
6/15/18	PROM	NSVD	No	6.14	No	No
Total Intrapartum Transfers from all sheets (3-B)						5

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Samantha Crickmore

Signature: 

Date Signed: 7/24/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Sharon Jean Elder-Cristi^{ano} License #: MW308
 Practice Name: Namaste Midwifery Care PLLC
 Address: 9543 Turkey Oak Bend
Orlando, FL 32817
 Phone Number: (321) 439 8451 Email: bridsmidwife@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
E	How many delivered at: Home:		0	Birthing Ctr:	0	Hospital:	0
	Number of unplanned: Breech:		0	Twins / Multiples	0		
G	Number of planned VBAC:		# of primary VBAC:	0	# of subsequent VBAC:	0	
	Number of water births:						
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Sharon Elder-Cristiano

Signature: Sharon Elder-Cristiano

Date Signed: 7-30-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kendra Ippel **License #:** MW 310
Practice Name: Previously with Commonsense Childbirth/The Birth Place
Address: Current: 1421 Bemis St SE Grand Rapids, MI 49506
Phone Number: 773-578-2728 **Email:** stelps@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:	0
	F	Number of unplanned: Breech:		Twins / Multiples			0
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		0
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kendra L Ippel

Signature: *K Ippel*

Date Signed: September 10 2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Michelle Hannah License #: 34
 Practice Name: Celebrate Birth
 Address: 1525 Edgewater Beach Dr.
Lakeland, FL 33805
 Phone Number: 863.680.2229 Email: celebratebirth@live.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					56
	B	Total number of maternity clients you accepted for care in the reporting period:					135
	C	Total number of deliveries you performed during reporting period:					
	D	Total number of licensed midwife students assigned to you during the reporting period:					30
E	How many delivered at:	Home: 5	Birthing Ctr: 25	Hospital: 0	30		
F	Number of unplanned:	Breech: 0	Twins / Multiples: 0			0	
G	Number of planned VBAC:	# of primary VBAC: 0	# of subsequent VBAC: 2			2	
H	Number of water births:					4	
I	Number of mothers requiring sutures:					9	
3	A	Number of mothers transferred antepartum (for medical reasons):					8
	B	Number of mothers transferred intrapartum:					4
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) \emptyset

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) \emptyset

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) \emptyset

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Michelle Hannah

Signature: *Michelle Hannah*

Date Signed: 7/20/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: RHONDA TODD HUGGINS License #: MW313
 Practice Name: TREE OF LIFE BIRTH+GYN
 Address: Practice: 1010 ARTHUR AVE, ORLANDO, FL 32806
 Home: 888 S. DEAN CIRCLE, DELTONA, FL 32738
 Phone Number: 407-474-9591 Email: JORTRINE@YAHOO

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					120
	B	Total number of maternity clients you accepted for care in the reporting period:					120
	C	Total number of deliveries you performed during reporting period:					31
	D	Total number of licensed midwife students assigned to you during the reporting period:					4
	E	How many delivered at: Home:	20	Birthing Ctr:	11	Hospital:	ϕ
F	Number of unplanned: Breech:	ϕ	Twins / Multiples	ϕ			ϕ
G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	2	3	
H	Number of water births:					9	
I	Number of mothers requiring sutures:					19	
3	A	Number of mothers transferred antepartum (for medical reasons):					8
	B	Number of mothers transferred intrapartum:					15
	C	Number of mothers transferred postpartum: (medical reasons)					ϕ
	D	Number of newborn transfers:					1
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					ϕ
	B	Number of fetal deaths / neonatal: (within seven days of birth)					ϕ
	C	Number of maternal deaths: (please submit separate report)					ϕ

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
7/10/17	PIH	unplanned	36	C-section & 35wgs
7/10/17	cardiac infection, liver infection	unplanned	35.4	C-section, hosp 2wks
8/11/17	Positive Antibody Screen Big E + hx pre-E	planned	23.4	UNK
11/7/17	Post-dates 41.6, HTN (ent'd care for herbal induction) unable to induce due to HTN tx to hosp.)	unplanned	41.6	C-section
3/16/18	hx PTL, PTD, C-section #2, short cervix	planned	19	UNK
4/8/18	PTD, PROM & 35wgs., breech	unplanned	35.1	C-section
4/13/18	Pt concerned over father hypokPP being passed to NB	planned	12	UNK
6/21/18	Decreased FM, sent to hospital, stat section due to umbilical thrombosis	unplanned	34	C-section, NICU x 10 days - no long term effects
Total Number of Antepartum Transfers from all sheet (3-A)				8

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7/17 ⁿ	FTP - postdates 42.1	C-sec.	No	7lb 12oz	No	No
7/24 ⁿ	FTP - postdates 42	NSVD	No	8lb 8oz	No	No
8/7/17	NRFHT	NSVD	No	7lb 10oz	No	No
9/5/17	Maternal Exhaustion Prolonged 2 nd stage, 1 st stage, mal-pos. NRFHT	C-sec.	No	7lb 9oz	No	No
9/29/17	Prolonged 2 nd stage, lack of descent	NSVD	No	9lbs 0oz	No	No
11/13/17	FTP, OP pres., NRFHT	C-sec.	No	5lbs 14oz	No	No
11/17/17	Prolonged 2 nd stage, OP, Poor M. efforts	NSVD	No	8lbs 6oz	No	No
12/19/17	FTP, Failed induction	NSVD	No	8lbs 8oz	No	No
1/17/18	FTP, PROM	NSVD	No	7lb 2oz	No	No
1/23/18	Pain Mgmt. prolonged 1 st	NSVD	No	8lbs	No	No
3/29/18	Pain Management	VBAC	No	6lbs 15oz	No	No
4/28/18	PROM, FTP	C-sec.	No	7lbs 8oz	No	No

Total Intrapartum Transfers from all sheets (3-B) *see attached*

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	Ø		
Total Number of Postpartum Transfers from all sheets (3-C)			Ø

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
7/3/17	Fetal Tachypnea 20 hours old	8lbs6oz	7/8	3 days	d/c w no treatment; observation only - resolved @ 48 hours.
			/ / / / / / / / / /		
			/ / / / / / / / / /		
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			/ / / / / / / / / /		
			/ / / / / / / / / /		
			/ / / / / / / / / /		
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	Ø					
Total Number of Fetal Death/Stillborn (4-A)						Ø

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

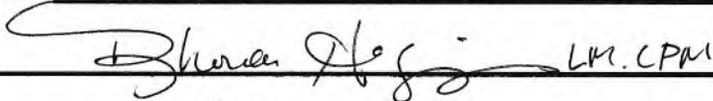
Number of Reports Attached

Total Number of Maternal Deaths (4-C)

0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: RHONDA TODD HUGGINS

Signature:  L.M. CPM

Date Signed: 07/20/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



**FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Michelle Cerami LM CPM License #: MW314
 Practice Name: East Coast Midwifery LLC
 Address: 408 E Ocean Ave Boynton Beach FL 33435
 Phone Number: 561-213-3765 Email: Michelle@eastcoastmidwifery.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					33	
	B	Total number of maternity clients you accepted for care in the reporting period:					31	
	C	Total number of deliveries you performed during reporting period:					26	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	17	Birthing Ctr:	9	Hospital:	0	26
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	1		1
	H	Number of water births:					11	
	I	Number of mothers requiring sutures:					14	
3	A	Number of mothers transferred antepartum (for medical reasons):					1	
	B	Number of mothers transferred intrapartum:					3	
	C	Number of mothers transferred postpartum: (medical reasons)					1	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
7/24/17	Delayed PPH	12hrs	Blood transfusion. D/c same day.

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.) None

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only) None

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

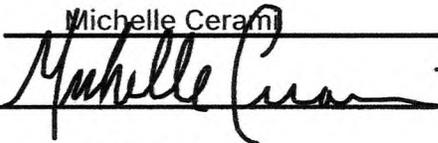
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant) None

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Michelle Cerami
Signature: 
Date Signed: 7/13/2018

**Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jacinda Golden License #: MW 315
 Practice Name: River City Homebirth LLC
 Address: 1319 Murray Drive
Jacksonville, FL 32205
 Phone Number: (904) 505-4848 Email: jaxhomebirth@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					25	
	B	Total number of maternity clients you accepted for care in the reporting period:					25	
	C	Total number of deliveries you performed during reporting period:					17	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	17	Birthing Ctr:	0	Hospital:	0	17
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	0	1	
	H	Number of water births:					7	
	I	Number of mothers requiring sutures:					3	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					1	
	C	Number of mothers transferred postpartum: (medical reasons)					1	
	D	Number of newborn transfers:					1	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
03/01/18	Malpresentation complicated by failure to progress.	C/S	Poor response to epidural anesthesia, general anesthesia used for delivery	8lb12oz	No	No
Total Intrapartum Transfers from all sheets (3-B)						1

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
12/24/18	Transferred with neonate. Placenta delivered at the hospital and second degree repair done.	3	No complications. Normal postpartum
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
12/24/18	Low APGARs, Poor transition, suspected meconium aspiration	7lb4oz	3 6	No	No treatment necessary. Healthy
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

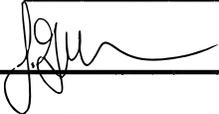
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Jacinda Golden

Signature: 

Date Signed: 07/20/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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Council of Licensed Midwifery
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Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

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SECTION I: PRACTICE INFORMATION

Midwife Name: Maya Duarte **License #:** MW316
Practice Name: Abundant Life Birth Center, LLC
Address: 611 SW Federal Hwy., STE M, Stuart Florida 34994
Phone Number: 772-200-4277 **Email:** Maya@thealbc.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					54	
	B	Total number of maternity clients you accepted for care in the reporting period:					54	
	C	Total number of deliveries you performed during reporting period:					37	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	19	Birthing Ctr:	18	Hospital:	0	37
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	3	# of subsequent VBAC:	1		4
	H	Number of water births:					10	
	I	Number of mothers requiring sutures:					16	
3	A	Number of mothers transferred antepartum (for medical reasons):					1	
	B	Number of mothers transferred intrapartum:					5	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					1	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
6/24/18	Clinical findings of Eclampsia	Unplanned	36WGA	C/S
Total Number of Antepartum Transfers from all sheet (3-A)				1

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
12/11/17	Arrest of Labor	C/S	NONE	3810	NO	NO
3/10/17	Arrest of labor	C/S	NONE	3692	NO	NO
8/10/17	Edema of the cervix FTP	NSVD	NONE	3674	NO	NO
9/29/17	Dysfunctional labor	NSVD	NONE	3447	NO	NO
10/8/18	PROM	NSVD	NONE	3084	NO	NO
Total Intrapartum Transfers from all sheets (3-B)						5

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Maya Suark
 Signature: Maya Suark
 Date Signed: 7/24/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Hailey C Sides License #: 317
 Practice Name: Birth Blossoms
 Address: 2107 Sunrise Blvd
Ft Pierce FL 34950
 Phone Number: 772-475-3986 Email: mamabear.H.S@gmail

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					40	
	B	Total number of maternity clients you accepted for care in the reporting period:					37	
	C	Total number of deliveries you performed during reporting period:					23	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	23	Birthing Ctr:	0	Hospital:	0	23
	F	Number of unplanned: Breech:	0	Twins / Multiples:	0			0
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	1		2
	H	Number of water births:					14	
	I	Number of mothers requiring sutures:					8	
3	A	Number of mothers transferred antepartum (for medical reasons):					2	
	B	Number of mothers transferred intrapartum:					3	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

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SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
9/4/17	History of repeat cesarean	Planned	39w	R. C/S
3/24/18	Fetal Abnormalities	UNPlanned	35w	# NSVD
Total Number of Antepartum Transfers from all sheet (3-A)				2

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
12/2/17	Pain Relief	vag	none	8#6	NO	Ø
9/24/17	Labor Stall	C/S	none	8#4	NO	Ø
4/25/18	Pain Relief	C/S	none	7#12	NO	Ø
Total Intrapartum Transfers from all sheets (3-B)						3

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Hailey C Sides
Signature: Hailey C Sides
Date: 7/18/18

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Heather Allen License #: MW 318
 Practice Name: Loving Arms Birth and Wellness Center
 Address: 1111 NE 25th Ave
Ocala FL 34470
 Phone Number: 352-575-3841 Email: midwifeheatherallen@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):				0	
	B	Total number of maternity clients you accepted for care in the reporting period:				0	
	C	Total number of deliveries you performed during reporting period:				9	
	D	Total number of licensed midwife students assigned to you during the reporting period:				0	
	E	How many delivered at: Home:	2	Birthing Ctr:	7	Hospital:	90
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	
	H	Number of water births:				4	
	I	Number of mothers requiring sutures:				0	
3	A	Number of mothers transferred antepartum (for medical reasons):				0	
	B	Number of mothers transferred intrapartum:				0	
	C	Number of mothers transferred postpartum: (medical reasons)				0	
	D	Number of newborn transfers:				0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)				0	
	C	Number of maternal deaths: (please submit separate report)				0	



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: HUI MAO License #: MW320
 Practice Name: NA
 Address: 1041 NE Zebraa Senda Jensen Beach FL 34857
 Phone Number: 772-678-9469 Email: Maryhui99@hotmail.com
 Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Teaching only					Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:				0	
	B	Total number of maternity clients you accepted for care in the reporting period:				0	
	C	Total number of deliveries you performed during reporting period:				0	
	D	Total number of licensed midwife students assigned to you during the reporting period:				0	
	E	How many delivered at: Home:	NA	Birthing Ctr:	NA	Hospital:	NA
	F	Number of unplanned: Breech:	NA	Twins / Multiples:	NA		
	G	Number of planned VBAC:	# of primary VBAC:	# of subsequent VBAC:		NA	
	H	Number of water births:				NA	
	I	Number of mothers requiring sutures:				NA	
3	A	Number of mothers transferred antepartum (for medical reasons):				NA	
	B	Number of mothers transferred intrapartum:				NA	
	C	Number of mothers transferred postpartum: (medical reasons)				NA	
	D	Number of newborn transfers:				NA	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				NA	
	B	Number of fetal deaths / neonatal: (within seven days of birth)				NA	
	C	Number of maternal deaths: (please submit separate report)				NA	

Teaching only

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	NA		

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	NA				

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NA					

Total Number of Fetal Death/Stillborn (4-A)

Teaching only

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NA			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Hui Mao

Signature: Hui Mao

Date Signed: 7/30/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Christy Hersey License #: MW 321
 Practice Name: UF Health, Heart2Heart Birthcenter, &
 Address: Agape Birth & wellness

Phone Number: 904-514-4928 Email: herseychristy@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)		
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:				53		
	B	Total number of maternity clients you accepted for care in the reporting period:				49		
	C	Total number of deliveries you performed during reporting period:				32		
	D	Total number of licensed midwife students assigned to you during the reporting period:				0		
	E	How many delivered at: Home:	3	Birthing Ctr:	29	Hospital:	0	32
	F	Number of unplanned: Breech:	0	Twins / Multiples:	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:				14		
	I	Number of mothers requiring sutures:				7		
3	A	Number of mothers transferred antepartum (for medical reasons):				0		
	B	Number of mothers transferred intrapartum:				3		
	C	Number of mothers transferred postpartum: (medical reasons)				2		
	D	Number of newborn transfers:				1		
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0		
	B	Number of fetal deaths / neonatal: (within seven days of birth)				0		
	C	Number of maternal deaths: (please submit separate report)				0		

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
9/22/17	ABP, fainting spells	2	Stable
4/2/18	3rd laceration	0	repaired - Stable
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
10/1/18	Failure to transition		8/9	6	Healthy After
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Christy Hersey
Signature: 
Date Signed: 7/29/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Anna Belen Larson **License #:** MW322
Practice Name: N/A
Address: PO Box Evinston, FL 32633
Phone Number: 352.591.3105 **Email:** annabelen13@gmail.com

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC: 0	# of primary VBAC:	0	# of subsequent VBAC:	0	0
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Anna Belen Larson

Signature: 

Date Signed: July 30, 2018

*Not currently in practice

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kerri Audette License #: MW 324
 Practice Name: _____
 Address: 3820 NW 10th Pl
Gainesville FL 32605
 Phone Number: 352-275-6731 Email: kerriaudette@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					0
	B	Total number of maternity clients you accepted for care in the reporting period: 1					1
	C	Total number of deliveries you performed during reporting period:					1
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	0	Birthing Ctr:	1	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	
	H	Number of water births:					1
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A				

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live Infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Kerri Audette

Signature: Kerri Audette

Date: 7-17-18



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Sandra Lobaina License #: MW325
 Practice Name: My Mom Glow
 Address: 3427 W 80th ST #101
Hialeah FL 33018
 Phone Number: (305) 600-8109 Email: my mom glow@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2	
A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 5
B	Total number of maternity clients you accepted for care in the reporting period: 5
C	Total number of deliveries you performed during reporting period: 2
D	Total number of licensed midwife students assigned to you during the reporting period: 0
E	How many delivered at: Home: 2 Birthing Ctr: 0 Hospital: 3
F	Number of unplanned: Breech: 0 Twins / Multiples: 0
G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0
H	Number of water births: 0
I	Number of mothers requiring sutures: 0
3	
A	Number of mothers transferred antepartum (for medical reasons): 1
B	Number of mothers transferred intrapartum: 2
C	Number of mothers transferred postpartum: (medical reasons) 0
D	Number of newborn transfers: 0
4	
A	Number of fetal deaths / stillborn: (midwife delivery only) 0
B	Number of fetal deaths / neonatal: (within seven days of birth) 0
C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
9/2/17	Low AFI in Postdate Bio	Unplanned	41	Vag
Total Number of Antepartum Transfers from all sheet (3-A)				1

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	Delivery Method	MOTHER	BIRTH WEIGHT	INFANT	
			Complications?		Admitted to NICU? If yes, reason and # of days	Neonatal Death?
9/2/17	Low AFI in Postdate Bio	Vag	None	7163oz	NO	NO
2/12/18	Prolonged ROM / NO labor	C/S	None	8167oz	NO	NO
5/9/18	Prolonged ROM / NO cervical change	C/S	None	8169oz	NO	NO
Total Intrapartum Transfers from all sheets (3-B)						2

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Sandra Lobaina
Signature: Sandra Lobaina
Date Signed: 7/16/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Sandra Lobaina License #: MW325
 Practice Name: Natural Birthworks
 Address: 513 Melaleuca Drive
Margate FL 33063
 Phone Number: (954)960-3213 Email: info@naturalbirthworks.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 49
	B	Total number of maternity clients you accepted for care in the reporting period: 49
	C	Total number of deliveries you performed during reporting period: 19
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 0 Birthing Ctr: 19 Hospital: 11
F	Number of unplanned: Breech: 0 Twins / Multiples: 0	
G	Number of planned VBAC: # of primary VBAC: # of subsequent VBAC:	
H	Number of water births: 6	
I	Number of mothers requiring sutures: 7	
3	A	Number of mothers transferred antepartum (for medical reasons): 2
	B	Number of mothers transferred intrapartum: 9
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 1
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
12/6/17	Irregular FAT / High blood sugar	5lb 12oz	9/9	yes / 6 days	SGA slow to transition
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Sandra Lobaina
Signature: Sandra Lobaina
Date Signed: 7/16/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Monica Theresa Pagliarulo-Wallace **License #:** MW326
Practice Name: Monica Pagliarulo-Wallace LM
Address: 102 Via De Casas Norte. Boynton Beach, Fl 33426
 (This my home address, I do not have a practice address)
Phone Number: 561-444-5242 **Email:** midwifemonica1111@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					4	
	B	Total number of maternity clients you accepted for care in the reporting period:					4	
	C	Total number of deliveries you performed during reporting period:					3	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	3	Birthing Ctr:	0	Hospital:	1	4
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:					2	
	I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					1	
	B	Number of mothers transferred intrapartum:					0	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
12/7/17	Preeclampsia	Unplanned	32	C/S
Total Number of Antepartum Transfers from all sheet (3-A)				1

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Monica Theresa Pagliarulo-Wallace LM, CPM

Signature: _____



Date Signed: 7/30/18

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Melissa Casey License #: MW 327
 Practice Name: Legacy Midwifery, LLC
 Address: Miami, FL 33157
Miami, FL 33157
 Phone Number: 305-484-0581 Email: legacymidwife@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					5
	B	Total number of maternity clients you accepted for care in the reporting period:					8
	C	Total number of deliveries you performed during reporting period:					2
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	2	Birthing Ctr:	0	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	1	
	H	Number of water births:					2
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					1
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
1-18-18	Post Dates	unplanned	42	C/S
Total Number of Antepartum Transfers from all sheet (3-A)				1

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					00

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Melissa Casey

Signature: Melissa Casey

Date Signed: 7-31-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Deborah Fuentes License #: MW328
 Practice Name: Lifesong Midwifery
 Address: 2575 N Toledo Blade #3
North Port FL 34289
 Phone Number: (941)264-6084 Email: Dfuentes@midwiferyschool.org

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 0
	B	Total number of maternity clients you accepted for care in the reporting period: 0
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
E	How many delivered at: Home: 2 Birthing Ctr: 0 Hospital: 0	
F	Number of unplanned: Breech: 0 Twins / Multiples: 0	
G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0	
H	Number of water births:	0
I	Number of mothers requiring sutures:	0
3	A	Number of mothers transferred antepartum (for medical reasons): 0
	B	Number of mothers transferred intrapartum: 0
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	None		
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	None		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	None					
Total Number of Fetal Death/Stillborn (4-A)						

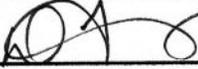
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	None			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Deborah Fuentes
Signature: 
Date Signed: 9/12/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Serena Burr License #: MW329
 Practice Name: _____
 Address: _____
 Phone Number: 914 299 7171 Email: midwifenserena@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care): 67
	B	Total number of maternity clients you accepted for care in the reporting period: 53
	C	Total number of deliveries you performed during reporting period: 32
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 17 Birthing Ctr: 15 Hospital: 0
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0
	G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0
	H	Number of water births: 9
	I	Number of mothers requiring sutures: 11
3	A	Number of mothers transferred antepartum (for medical reasons): 5
	B	Number of mothers transferred intrapartum: 11
	C	Number of mothers transferred postpartum: (medical reasons) 5
	D	Number of newborn transfers: 2
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within 7 days of life) 0
	C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
07/28/2017	placental deficiency	unplanned	30wga	c/s
08/24/2017	6/8 BPP	unplanned	41wga	vag
10/04/2017	Advanced maternal age	unplanned	42wga	vag
11/20/2017	Lots of fear surrounding out of hospital delivery	planned	37wga	vag
12/29/2017	PIH/Preeclampsia	unplanned	40wga	vag
Total Number of Antepartum Transfers from all sheet (3-A)				

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
07/03/2017	cervical swelling/FTP	vag	none		no	no
07/05/2017	decels second stage	vag	vacuum/episiotomy	7"7	no	no
07/11/2017	precipitous labor	vag	none	6	no	no
07/30/2017	FTP	vag	none	7"8	no	no
08/15/2017	FTP	vag	vasovagal response with induction	9lb	no	no
09/13/2017	pain management	vag	none		no	no
09/19/2017	prolonged pushing/inadequate ctx	vag	none	9"8	no	no
10/07/2017	PPROM/Advanced maternal age	vag	none	11"3	no	no
11/17/2017	Footling Breech	vag	none	8"8	no	no
01/03/2018	FTP/PPROM	vag	none	10"3	no	no
03/21/2018	FTP/PPROM	Ces	none	8	no	no
Total Intrapartum Transfers from all sheets (3-B)						

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
01/16/2018	Low BP	24 hours	pt stable/IV fluids/monitored
09/05/2017	4th degree laceration	24hrs	OR repair
10/24/2017	3rd degree laceration	6hrs	ER repair
5/28/2018	PPH	48hrs	Blood Transfusion/Stable
5/29/2018	Vasovagal response to cytotec	24hrs	WNL
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
7/30/17	Shoulder Dystocia	9lb 8oz	6 / 7	yes	Infant Torticollis/brain scans normal
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Serena Burr

Signature: 

Date Signed: 07/30/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Brooke Schmoe License #: MW330
 Practice Name: The Midwife Bus
 Address: 5700 E Irlo Bronson Memorial Hwy
 Phone Number: 913-683-3874 Email: brookeschmoe@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					0	
	B	Total number of maternity clients you accepted for care in the reporting period:					0	
	C	Total number of deliveries you performed during reporting period:					0	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:					0	
	I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					0	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	NA			
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
	NA					
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	NA		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	NA		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NA					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NA			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Brooke Schmoe

Signature: 

Date Signed: 7/27/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Erica Barclay **License #:** MW331
Practice Name: Barefoot Birth
Address: 12527 Killian St
 Spring Hill, FL 34609
Phone Number: 352.584.5113 **Email:** erica@barefootbirth.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					45	
	B	Total number of maternity clients you accepted for care in the reporting period:					45	
	C	Total number of deliveries you performed during reporting period:					31	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	27	Birthing Ctr:	0	Hospital:	4	31
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			
	G	Number of planned VBAC: # of primary VBAC:	0	# of subsequent VBAC:	1		1	
	H	Number of water births:					18	
	I	Number of mothers requiring sutures:					2	
3	A	Number of mothers transferred antepartum (for medical reasons):					9	
	B	Number of mothers transferred intrapartum:					4	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					1	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0 <input type="checkbox"/>	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
8/24/17	SCH/unresolved placental abruption & previa	planned		unknown
9/28/17	GDM, secondary IUGR & HTN at term	unplanned		NSVD
11/10/17	Postdates, failed induction after previous cesarean	unplanned		repeat c/s
11/19/17	PROM, no onset of labor	unplanned		NSVD
12/27/17	Postdates, induction for failed BPP/NST	unplanned		NSVD
1/16/18	Cardiac "episodes", tachycardia, murmur	planned		unknown
2/08/18	Multiple gestation	planned		unknown
5/18/18	Postdates, client elected induction	planned		NSVD
6/15/18	AMA with routine monitoring, failed BPP/NST	unplanned		NSVD

Total Number of Antepartum Transfers from all sheet (3-A) **9**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
7/15/17	FTP, maternal exhaustion	C/S	None	7.4#	No	0
1/06/18	NRFHT during 2nd stage	Vaginal	Vacuum/Kiwi assisted	8#	No	0
5/22/18	FTP, maternal exhaustion	NSVD	Retained placenta / OB Management	6.8#	No	0
6/13/18	VBA2C, FTP with excellent RUC	C/S	True CPD	7#	No	0

Total Intrapartum Transfers from all sheets (3-B) **4**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
12/05/17	Respiratory Distress	9.1#	8/9	yes, 2	NICU for observ. X-Rays, some fluid on lungs
Total Newborn Transfers from all sheets(3-D)					1

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Erica Barclay LM, LMT

Signature: 

Date Signed: 07/16/18

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Andrea Reace License #: MW332
 Practice Name: Birth & Wellness Center of Gainesville
 Address: 607 E. University Ave
Gainesville FL 32601
 Phone Number: 352-372-4784 Email: miwareece@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2 A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 58
B	Total number of maternity clients you accepted for care in the reporting period: 58
C	Total number of deliveries you performed during reporting period: 21
D	Total number of licensed midwife students assigned to you during the reporting period: 0
E	How many delivered at: Home: 4 Birthing Ctr: 17 Hospital: 0
F	Number of unplanned: Breech: 0 Twins / Multiples: 0
G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 1
H	Number of water births: 11
I	Number of mothers requiring sutures: 12
3 A	Number of mothers transferred antepartum (for medical reasons): 4
B	Number of mothers transferred intrapartum: 2
C	Number of mothers transferred postpartum: (medical reasons) 2
D	Number of newborn transfers: 0
4 A	Number of fetal deaths / stillborn: (midwife delivery only) 0
B	Number of fetal deaths / neonatal: (within seven days of birth) 0
C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
8/15/17	greater than 42wga	planned	42	
12/3/17	PPROM at 35w1d	unplanned	35.1	NSVD
1/8/18	low hgb	planned	38	NSVD
4/10/18	previous LGA with shoulder dystocia	planned	39	NSVD

Total Number of Antepartum Transfers from all sheet (3-A) **5**

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
9/3/17	Exhaustion/FTP	C/S	none	?	NONE	∅
9/30/17	FTP during 2 nd stage	C/S	none	7lb6.9oz	NONE	∅

Total Intrapartum Transfers from all sheets (3-B) **2**

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
10/3/17	PPH	2	stable
12/1/17	accidental unassisted homebirth	2	Stable

Total Number of Postpartum Transfers from all sheets (3-C) 2

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	<i>N</i>			
	<i>A</i>			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	<i>0</i>

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Andrea Reece
Signature: *Andrea Reece*
Date Signed: 7.25.18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Lisa Russell License #: MW333
 Practice Name: Birth Center of St. Pete
 Address: 1405 Dr. MLK Jr. H.N.
St. Pete, FL 33704
 Phone Number: 727.417.0296 Email: midwife.lisa333@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request, do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2	
A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <u>20</u>
B	Total number of maternity clients you accepted for care in the reporting period: <u>14</u>
C	Total number of deliveries you performed during reporting period: <u>9</u>
D	Total number of licensed midwife students assigned to you during the reporting period: <u>0</u>
E	How many delivered at: Home: <u>1</u> Birthing Ctr: <u>8</u> Hospital: <u>0</u>
F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>
G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u>
H	Number of water births: <u>3</u>
I	Number of mothers requiring sutures: <u>3</u>
3	
A	Number of mothers transferred antepartum (for medical reasons): <u>1</u>
B	Number of mothers transferred intrapartum: <u>4</u>
C	Number of mothers transferred postpartum: (medical reasons) <u>1</u>
D	Number of newborn transfers: <u>0</u>
4	
A	Number of fetal deaths / stillborn: (midwife delivery only) <u>0</u>
B	Number of fetal deaths / neonatal: (within seven days of birth) <u>0</u>
C	Number of maternal deaths: (please submit separate report) <u>0</u>

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
11-27-17	Gestational hypertension, postdates	Unplanned	42	NSVD
Total Number of Antepartum Transfers from all sheet (3-A)				1

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		BIRTH WEIGHT	INFANT	
		Delivery Method	Complications?		Admitted to NICU? If yes, reason and # of days	Neonatal Death?
1-1-18	Pain Management	NSVD	No	#7-4oz	No	No
1-12-18	PROM	NSVD	No	#8-6oz	No	No
2-10-18	Failure to Progress	CS		#9-10oz	No	No
2-6-18	FTP + meconium	CS		UNK	No	No
Total Intrapartum Transfers from all sheets (3-B)						4

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
11-16-17	Maternal Fever	1	Stable

Total Number of Postpartum Transfers from all sheets (3-C) 1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Lisa Russell
Signature: [Handwritten Signature]
Date Signed: 9-6-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jorge Rosgado License #: 334
 Practice Name: Jorge Rosgado
 Address: 562 E 94 ST Tallahassee FL 323013
 Phone Number: 786 718 0894 Email: Jorge.Rosgado@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					46	
	B	Total number of maternity clients you accepted for care in the reporting period:					46	
	C	Total number of deliveries you performed during reporting period:					0	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	0	Birthing Ctr:	0	Hospital:	0	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0		0
	H	Number of water births:					0	
	I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					0	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A				

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Jorge Bosque
Signature: [Handwritten Signature]
Date Signed: 07/25/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ License #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					
	B	Total number of maternity clients you accepted for care in the reporting period:					
	C	Total number of deliveries you performed during reporting period:					
	D	Total number of licensed midwife students assigned to you during the reporting period:					
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:	
	F	Number of unplanned: Breech:		Twins / Multiples			
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		
	H	Number of water births:					
	I	Number of mothers requiring sutures:					
3	A	Number of mothers transferred antepartum (for medical reasons):					
	B	Number of mothers transferred intrapartum:					
	C	Number of mothers transferred postpartum: (medical reasons)					
	D	Number of newborn transfers:					
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					
	B	Number of fetal deaths / neonatal: (within seven days of birth)					
	C	Number of maternal deaths: (please submit separate report)					

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

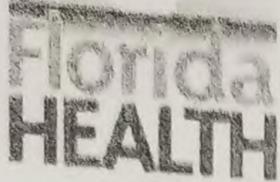
Signature:  _____

Date Signed: _____

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Sorell Paqliara License #: MW336
 Practice Name: Gainesville Midwives
 Address: 10213 NW 6th Pl
Gainesville FL 32607
 Phone Number: 352-246-3936 Email: sorellpaqliara@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <input type="text" value="0"/>
	B	Total number of maternity clients you accepted for care in the reporting period: <input type="text" value="0"/>
	C	Total number of deliveries you performed during reporting period: <input type="text" value="0"/>
	D	Total number of licensed midwife students assigned to you during the reporting period: <input type="text" value="0"/>
	E	How many delivered at: Home: <input type="text" value="0"/> Birthing Ctr: <input type="text" value="0"/> Hospital: <input type="text" value="0"/>
	F	Number of unplanned: Breech: <input type="text" value="0"/> Twins / Multiples: <input type="text" value="0"/>
	G	Number of planned VBAC: # of primary VBAC: <input type="text" value="0"/> # of subsequent VBAC: <input type="text" value="0"/>
	H	Number of water births: <input type="text" value="0"/>
	I	Number of mothers requiring sutures: <input type="text" value="0"/>
	3	A
B		Number of mothers transferred intrapartum: <input type="text" value="0"/>
C		Number of mothers transferred postpartum: (medical reasons) <input type="text" value="0"/>
D		Number of newborn transfers: <input type="text" value="0"/>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <input type="text" value="0"/>
	B	Number of fetal deaths / neonatal: (within seven days of birth) <input type="text" value="0"/>
	C	Number of maternal deaths: (please submit separate report) <input type="text" value="0"/>

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	none		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	none				
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	none					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	none			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	
	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Sorell Pagliara
 Signature: Sorell Pagliara
 Date Signed: August 28, 2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

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AUG 07 2018

ANNUAL REPORT OF MIDWIFERY PRACTICE

RECEIVED

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Amy Truglio License #: MW 337
 Practice Name: Celebrate Birth
 Address: ~~4737~~ 1525 Edgewater Beach Dr
Lakeland, FL 33805
 Phone Number: 863-680-2229 Email: Celebratebirth@live.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					30
	B	Total number of maternity clients you accepted for care in the reporting period:					113
	C	Total number of deliveries you performed during reporting period:					5
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	1	Birthing Ctr:	4	Hospital:	
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		0
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:	1	1
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					2
3	A	Number of mothers transferred antepartum (for medical reasons):					1
	B	Number of mothers transferred intrapartum:					2
	C	Number of mothers transferred postpartum: (medical reasons)					1
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
10/24	Poor recovery	1	nml; recovering well
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Amy Truglio

Signature: Amy Truglio

Date Signed: 7/30/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ License #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____
	F	Number of unplanned: Breech: _____ Twins / Multiples: _____
	G	Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____
	H	Number of water births:
	I	Number of mothers requiring sutures:
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____

Signature: _____

Date Signed: _____

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
MQA.Midwifery@FLHealth.gov**



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Mandy Rojas License #: MW 339
 Practice Name: Gift of Life Pregnancy Services
 Address: 512 35th St WPB, FL 33407

Phone Number: 954-373-4198 Email: mymidwife_mandy@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					12
	B	Total number of maternity clients you accepted for care in the reporting period:					9
	C	Total number of deliveries you performed during reporting period:					7
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	7	Birthing Ctr:	0	Hospital:	2
	F	Number of unplanned: Breech:	0	Twins / Multiples:	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:		0
	H	Number of water births:					3
	I	Number of mothers requiring sutures:					3
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
N/A			
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days.	Outcome
N/A					
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
N/A						
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
<i>NA</i>				
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Mandy Rojas L.M.
 Signature: *Mandy Rojas*
 Date Signed: 9/10/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jeanette Hernandez License #: MW340
 Practice Name: _____
 Address: 1190 NW 95th Street Miami, FL 33150
 Phone Number: 7864496989 Email: jeanettehg23@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number	Total(s)
2 A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 30
B	Total number of maternity clients you accepted for care in the reporting period: 20
C	Total number of deliveries you performed during reporting period: 0
D	Total number of licensed midwife students assigned to you during the reporting period: 0
E	How many delivered at: Home: <input type="radio"/> Birthing Ctr: <input type="radio"/> Hospital: <input type="radio"/> 0
F	Number of unplanned: Breech: <input type="radio"/> Twins / Multiples: <input type="radio"/> 0
G	Number of planned VBAC: # of primary VBAC: <input type="radio"/> # of subsequent VBAC: <input type="radio"/> 0
H	Number of water births: 0
I	Number of mothers requiring sutures: 0
3 A	Number of mothers transferred antepartum (for medical reasons): 0
B	Number of mothers transferred intrapartum: 0
C	Number of mothers transferred postpartum: (medical reasons) 0
D	Number of newborn transfers: 0
4 A	Number of fetal deaths / stillborn: (midwife delivery only) 0
B	Number of fetal deaths / neonatal: (within seven days of birth) 0
C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
8.10.17	Client started uterine contractions	Unplanned	30	
9.30.17	Client decided OB care (VBAAC)	Planned	31	C/S
10.01.17	Client decided hospital delivery	Planned	37	
11.14.17	Client had high blood pressure	Unplanned	36	
11.30.17	Client had a miscarriage	Unplanned	12	
12.2.17	Client's baby had a congenital malformation	Unplanned	17	Termination
12.23.17	Client decided hospital delivery	Planned	38	
02.1.18	Client had a blighted ovum	Unplanned	8	
03.15.18	Client decided OB care	Planned	33	
05.23.18	Client decided OB care	Planned	27	
06.1.18	Client started preterm labor	Unplanned	35	
Total Number of Antepartum Transfers from all sheet (3-A)				10

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
Total Intrapartum Transfers from all sheets (3-B)						0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

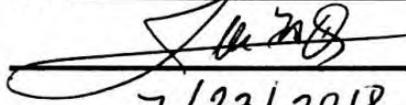
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live Infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Jeanette Hernandez
 Signature: 
 Date Signed: 7/23/2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

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 Tallahassee, FL 32399-3256
 MQA.Midwifery@FIHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Naomi Mizrachi License #: DMW 341
 Practice Name: Sacred Journey Midwifery and Lifesong Midwifery
 Address: 4620 Gail Blvd Naples FL 34104
2575 N. Toledo Blade Blvd Suite 3 North Port FL
 Phone Number: 239-777-4691 Email: midwifenaomi@gmail.com 39289

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:				23	
	B	Total number of maternity clients you accepted for care in the reporting period:				16	
	C	Total number of deliveries you performed during reporting period:				11	
	D	Total number of licensed midwife students assigned to you during the reporting period:				0	
E	How many delivered at: Home:	11	Birthing Ctr:	0	Hospital:	0	11
F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	0	
H	Number of water births:					2	
I	Number of mothers requiring sutures:					1	
3	A	Number of mothers transferred antepartum (for medical reasons):				0	
	B	Number of mothers transferred intrapartum:				4	
	C	Number of mothers transferred postpartum: (medical reasons)				0	
	D	Number of newborn transfers:				0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)				0	
	C	Number of maternal deaths: (please submit separate report)				0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				<input checked="" type="checkbox"/>

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	<input checked="" type="checkbox"/>
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Printed Name: Naomi Mizrachi
Signature: *Naomi Mizrachi*
Date Signed: 6/30/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FIHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: AMANDA PITTMAN **License #:** MW342
Practice Name: MIDWIVES COOPERATIVE LLC
Address: 2602 NW 6TH STREET, STE B,
GAINESVILLE, FL 32609
Phone Number: 352 377 3879 **Email:** midwivescooperative@hotmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:				6
	B	Total number of maternity clients you accepted for care in the reporting period:				6
	C	Total number of deliveries you performed during reporting period:				5
	D	Total number of licensed midwife students assigned to you during the reporting period:				1
	E	How many delivered at: Home:	5	Birthing Ctr:	0	Hospital:
F	Number of unplanned: Breech:	0	Twins / Multiples	0		
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	
H	Number of water births:					
I	Number of mothers requiring sutures:					3
3	A	Number of mothers transferred antepartum (for medical reasons):				0
	B	Number of mothers transferred intrapartum:				1
	C	Number of mothers transferred postpartum: (medical reasons)				1
	D	Number of newborn transfers:				0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0
	B	Number of fetal deaths / neonatal: (within seven days of birth)				0
	C	Number of maternal deaths: (please submit separate report)				0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
	NONE			
Total Number of Antepartum Transfers from all sheet (3-A)				0

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
9/6/17	PRE-TERM LABOR	NSVD	NONE	5lb 12oz	NO	NO
Total Intrapartum Transfers from all sheets (3-B)						1

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
9/24/17	3rd degree laceration	not admitted	good
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	NONE		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	NONE					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NONE			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	NONE	
Total Number of Maternal Deaths (4-C)		0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: AMANDA PITTMAN
 Signature: *A Pittman*
 Date Signed: 6/27/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Maria Elena Rendón de Daher License #: MW 343

Practice Name: _____

Address: 10936 NW 67th St. Doral FL 33178

Phone Number: 7865148272 Email: mariaelenadahere@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
E	How many delivered at: Home:	<input type="radio"/>	Birthing Ctr:	<input type="radio"/>	Hospital:	<input type="radio"/>	
F	Number of unplanned: Breech:	<input type="radio"/>	Twins / Multiples	<input type="radio"/>			
G	Number of planned VBAC:	# of primary VBAC:	<input type="radio"/>	# of subsequent VBAC:	<input type="radio"/>		
H	Number of water births:					0	
I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: *Maria Elena Rendón de Daher*
 Signature: *[Handwritten Signature]*
 Date Signed: 07/29/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Lanee Webb License #: MW 344
 Practice Name: The Birth Place (Employee) / Celebrate Birth (Employee)
 Address: 213 S Dillard St. / 1525 Edgewater Beach Dr
Winter Garden FL 34787 / Lakeland FL 33805
 Phone Number: 785 543 4225 Email: laneedyan@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					36
	B	Total number of maternity clients you accepted for care in the reporting period:					44
	C	Total number of deliveries you performed during reporting period:					18
	D	Total number of licensed midwife students assigned to you during the reporting period:					16 Err
	E	How many delivered at: Home:	<input type="radio"/>	Birthing Ctr:	12	Hospital:	3
	F	Number of unplanned: Breech:	<input type="radio"/>	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	<input type="radio"/>	# of subsequent VBAC:	0	
	H	Number of water births:					4
	I	Number of mothers requiring sutures:					6
3	A	Number of mothers transferred antepartum (for medical reasons):					2
	B	Number of mothers transferred intrapartum:					2
	C	Number of mothers transferred postpartum: (medical reasons)					1
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
2/13/18	PIH	unplanned	term	C/S
6/2018	Pain management	unplanned	term	vaginal
Total Number of Antepartum Transfers from all sheet (3-A)				

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASDN FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
2/13/18	FTP	VD	—	—	—	No
3/26/18	PIH	VD	magnesium	—	—	No
Total Intrapartum Transfers from all sheets (3-B)						

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
2/23/18	Retained placenta	not admitted	Placenta removed/Stable

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Lanee Ryan Webb
Signature: 
Date Signed: 7/26/2017

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Margo Danielle Keane License #: MW 345
 Practice Name: Midwife Love
 Address: 703 W Weatherbee Rd. Fort Pierce FL 34982
 Phone Number: (772) 216-6900 Email: margokeane14@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					50	
	B	Total number of maternity clients you accepted for care in the reporting period:					50	
	C	Total number of deliveries you performed during reporting period:					15	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	15	Birthing Ctr:	0	Hospital:	0	15
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	0		1
	H	Number of water births:					7	
	I	Number of mothers requiring sutures:					9	
3	A	Number of mothers transferred antepartum (for medical reasons):					4	
	B	Number of mothers transferred intrapartum:					4	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
09/23/17	Heavy bleeding in early labor and unreassuring fetal movement	Unplanned	39.3	NSVD
09/30/17	Breech, oligohydramnios, and unreassuring fetal movement	Planned	40.6	C/S
10/10/17	PROM	Unplanned	34	NSVD
03/19/18	Suspected placental abruption	Unplanned	39.4	C/S
Total Number of Antepartum Transfers from all sheet (3-A)				4

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
10/24/17	No fetal descent q. 3hrs of pushing/CPD	C/S	Cervix was torn during c/s	8lb 10	No	No
11/25/17	FTP at 6cm	C/S	No	8lb 2	No	No
12/18/17	OP/Military presentation, FTP @ 9cm	C/S	No	7lb 8	No	No
05/02/18	No fetal descent q. 3hrs of pushing	C/S	No	7lb 13	No	No
Total Intrapartum Transfers from all sheets (3-B)						4

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
N/A			
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
N/A					
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
N/A						
N/A						
N/A						
N/A						
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Margo Keane

Signature: 

Date Signed: 07/20/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

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JUL 30 2018

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

RECEIVED

SECTION I: PRACTICE INFORMATION

Midwife Name: Cynda Kelley **License #:** MW346
Practice Name: Abundant Life Birth Center, LLC
Address: 611 SW Federal Hwy., STE M, Stuart Florida 34994
Phone Number: 772-200-4277 **Email:** Cynda@thealbc.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					55
	B	Total number of maternity clients you accepted for care in the reporting period:					55
	C	Total number of deliveries you performed during reporting period:					32
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	15	Birthing Ctr:	18	Hospital:	0
F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	Number of planned VBAC: # of primary VBAC:	1	# of subsequent VBAC:	0			1
H	Number of water births:					11	
I	Number of mothers requiring sutures:					4	
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					2
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

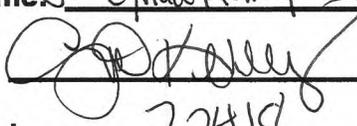
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Cynda Kelley
 Signature: 
 Date Signed: 7/24/18

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Miguel A Rodriguez Perez License #: MW347
 Practice Name: First Class OB GYN P.A.
 Address: 1951 SW 172 Ave #212 Miramar
Florida, 33029
 Phone Number: 9549408449 Email: drmiguelalex@yahoo.com
Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 54
	B	Total number of maternity clients you accepted for care in the reporting period: 54
	C	Total number of deliveries you performed during reporting period: 0
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: <input type="radio"/> Birthing Ctr: <input type="radio"/> Hospital: <input type="radio"/> 0
F	Number of unplanned: Breech: <input type="radio"/> Twins / Multiples: <input type="radio"/>	0
	Number of planned VBAC: # of primary VBAC: <input type="radio"/> # of subsequent VBAC: <input type="radio"/>	0
G	Number of planned VBAC: # of primary VBAC: <input type="radio"/> # of subsequent VBAC: <input type="radio"/>	0
H	Number of water births: 0	
I	Number of mothers requiring sutures: 0	
3	A	Number of mothers transferred antepartum (for medical reasons): 0
	B	Number of mothers transferred intrapartum: 0
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Miguel Alexander Rodriguez Perez
 Signature: *MR 12140924*
 Date Signed: 07/24/2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Rosio C. Ortega Araujo License #: MW 348
 Practice Name: not practicing
 Address: 8215 SW 152 Ave Apt G 418. Miami Kendall, 33193 FL

Phone Number: 786-9917780 Email: drarosioortega@yahoo.com.ar

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number					Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:			0	
	B	Total number of maternity clients you accepted for care in the reporting period:			0	
	C	Total number of deliveries you performed during reporting period:			0	
	D	Total number of licensed midwife students assigned to you during the reporting period:			0	
	E	How many delivered at: Home:	Birthing Ctr:	Hospital:	0	
	F	Number of unplanned: Breech:	Twins / Multiples		0	
	G	Number of planned VBAC:	# of primary VBAC:	# of subsequent VBAC:	0	
	H	Number of water births:			0	
	I	Number of mothers requiring sutures:			0	
	3	A	Number of mothers transferred antepartum (for medical reasons):			0
		B	Number of mothers transferred intrapartum:			0
C		Number of mothers transferred postpartum: (medical reasons)			0	
D		Number of newborn transfers:			0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)			0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)			0	
	C	Number of maternal deaths: (please submit separate report)			0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

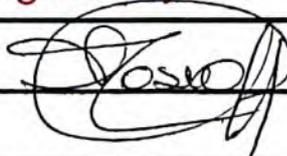
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Rosio C. Ortega Araujo
 Signature: Rosio Ortega 
 Date Signed: 07/30/2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Amanda S. Mann License #: MW349
 Practice Name: Lakeland Midwifery Care, Inc.
 Address: Lakeland, FL 33803
Lakeland, FL 33803
 Phone Number: 863-632-2323 Email: amanda.mannromey@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					41
	B	Total number of maternity clients you accepted for care in the reporting period:					41
	C	Total number of deliveries you performed during reporting period:					17
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	15	Birthing Ctr:	2	Hospital:	
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	
	H	Number of water births:					2
	I	Number of mothers requiring sutures:					2
3	A	Number of mothers transferred antepartum (for medical reasons):					7
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
N/A			
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
N/A					
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
N/A						
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
N/A				
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Amanda Mann

Signature: *Amanda Mann, LM*

Date Signed: 07/30/2018

**Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256**

or

**Email to:
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**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Cori Lynn Duarte License #: MW350
 Practice Name: Labor of Love Birth Center
 Address: 106 Myrtle Ridge Rd, Lutz, FL 33549
 Phone Number: (813) 949-1185 Email: Cori.laboroflove@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					35	
	B	Total number of maternity clients you accepted for care in the reporting period:					35	
	C	Total number of deliveries you performed during reporting period:					35	
	D	Total number of licensed midwife students assigned to you during the reporting period:					∅	
	E	How many delivered at: Home:	1	Birthing Ctr:	34	Hospital:	∅	35
	F	Number of unplanned: Breech:	∅	Twins / Multiples	∅			∅
	G	Number of planned VBAC:	# of primary VBAC:	∅	# of subsequent VBAC:	∅		∅
	H	Number of water births:					19	
	I	Number of mothers requiring sutures:					16	
3	A	Number of mothers transferred antepartum (for medical reasons):					2	
	B	Number of mothers transferred intrapartum:					1	
	C	Number of mothers transferred postpartum: (medical reasons)					∅	
	D	Number of newborn transfers:					∅	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					∅	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					∅	
	C	Number of maternal deaths: (please submit separate report)					∅	

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(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A		/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: Cori Lynn Duarte
 Signature: Cori L Duarte
 Date: 7/1/18

FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
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ANNUAL REPORT OF MIDWIFERY PRACTICE

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SECTION I: PRACTICE INFORMATION

Midwife Name: Behive Yenikomsu License #: MW351
 Practice Name: AGAPE and Heart 2 Heart
 Address: 6240 contessa drive # 308
Orlando, FL 32829
 Phone Number: 405-772-6213 Email: behive.yenikomsu@baylor.edu
 Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number		Total(s)
2	A	Total number of Initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 40
	B	Total number of maternity clients you accepted for care in the reporting period: 34
	C	Total number of deliveries you performed during reporting period: 29
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 7 Birthing Ctr: 25 Hospital: 0 32
	F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0
	G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0 0
	H	Number of water births: 12
	I	Number of mothers requiring sutures: 6
3	A	Number of mothers transferred antepartum (for medical reasons): 1
	B	Number of mothers transferred intrapartum: 2
	C	Number of mothers transferred postpartum: (medical reasons) 1
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days In Hospital	Outcome/Condition on Discharge
6/2017	vitals unstable 4hrs PP	1	stable
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Behiye Yenikomsu

Signature: 

Date Signed: 7.27.18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Rolando Morell Artola License #: MW 352
 Practice Name: Global OB / GYN centers
 Address: 10067 Pines Blvd. Suit. B Pines, FL 33024
 Phone Number: 954-430-7777 Email: rolyma2015@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					63
	B	Total number of maternity clients you accepted for care in the reporting period:					63
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	<input type="radio"/>	Birthing Ctr:	<input type="radio"/>	Hospital:	<input type="radio"/>
	F	Number of unplanned: Breech:	<input type="radio"/>	Twins / Multiples	<input type="radio"/>		
	G	Number of planned VBAC:	# of primary VBAC:	<input type="radio"/>	# of subsequent VBAC:	<input type="radio"/>	
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

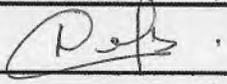
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Polando Morell Artola.
Signature: 
Date Signed: 7/20/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH
Council of Licensed
Midwifery 4052 Bald
 Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
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ANNUAL REPORT OF MIDWIFERY PRACTICE

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SECTION I: PRACTICE INFORMATION	
Midwife Name: <u>Rachael Larsen</u>	License #: <u>MW 353</u>
Practice Name: <u>Fruitful/Vine/Modern Midwife</u>	
Address: <u>130 Jackson Rd</u> <u>Atlantic Beach FL 32253</u>	
Phone Number: <u>2069415774</u>	Email: <u>ModernMidwifeFL@gmail.com</u>

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number			Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:	42
	B	Total number of maternity clients you accepted for care in the reporting period:	42
	C	Total number of deliveries you performed during reporting period:	11
	D	Total number of licensed midwife students assigned to you during the reporting period:	0
	E	How many delivered at: Home: <u>8</u> Birthing Ctr: <u>3</u> Hospital: <u>0</u>	
	F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>	
	G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u>	
	H	Number of water births:	1
	I	Number of mothers requiring sutures:	1/2
3	A	Number of mothers transferred antepartum (for medical reasons):	0
	B	Number of mothers transferred intrapartum:	7

	C	Number of mothers transferred postpartum: (medical reasons)	<input type="radio"/>
	D	Number of newborn transfers:	<input type="radio"/>
4	A	Number of fetal deaths / stillborn: (midwife delivery only)	<input type="radio"/>
	B	Number of fetal deaths / neonatal: (within 7 days of life)	<input type="radio"/>
	C	Number of maternal deaths: (please submit separate report)	<input type="radio"/>

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
Total Number of Antepartum Transfers from all sheet (3-A)				

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	MOTHER		INFANT		
		Delivery Method	Complications?	BIRTH WEIGHT	Admitted to NICU? If yes, reason and # of days	Neonatal Death?
6/16/14	PROM	NSVD		7lb 2oz	no	
3/4/14	Misc / no FHR	NSVD	neural Cord	6lb 3oz		Y
11/23/17	decel's, Bleeding (unknown)	NSVD		6lb 8oz	no	
12/15/17	PROM	NSVD		6lb 5oz	no	
6/13/15	Decels (FHR)	NSVD		7lb 0oz	no	
4/23/15	+ BP / P / Temp	NSVD		9lb 4oz	no	
11/12/17	+ BP	NSVD		9lb 10oz	no	
Total Intrapartum Transfers from all sheets (3-B)						

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A				
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Printed Name:

Rachael Larsen

Signature:

[Handwritten Signature]

Date Signed:

7/11/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:

MQA.Midwifery@FIHealth.gov

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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

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SECTION I: PRACTICE INFORMATION

Midwife Name: Courtney Hilliard License #: MW#354
 Practice Name: Heart 2 Heart Birthing center
 Address: 1110 Lexington green lane
Sanford FL 32771
 Phone Number: 727 510 0704 Email: cohilliard3@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					30	
	B	Total number of maternity clients you accepted for care in the reporting period:					40	
	C	Total number of deliveries you performed during reporting period:					33	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	<input type="radio"/>	Birthing Ctr:	33	Hospital:	<input type="radio"/>	33
	F	Number of unplanned: Breech:	<input type="radio"/>	Twins / Multiples	<input type="radio"/>			0
	G	Number of planned VBAC:	<input type="radio"/>	# of primary VBAC:	<input type="radio"/>	# of subsequent VBAC:	<input type="radio"/>	0
	H	Number of water births:					3	
	I	Number of mothers requiring sutures:					3	
3	A	Number of mothers transferred antepartum (for medical reasons):					2	
	B	Number of mothers transferred intrapartum:					7	
	C	Number of mothers transferred postpartum: (medical reasons)					1	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
8/31	retained placenta	1	stable, expelled after anesthesia

Total Number of Postpartum Transfers from all sheets (3-C) 1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: COURTNEY HILLIARD

Signature: 

Date Signed: JULY 24 2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jennifer Stone LM, LPN, CPM License #: mw355
 Practice Name: Sunshine State Midwifery, Barefoot Birth, Birth Center of Jacksonville
 Address: 1988 Ashston St
Middleburg, FL 32068
 Phone Number: 904-654-8647 Email: rhythmsisters@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 4
	B	Total number of maternity clients you accepted for care in the reporting period: 12
	C	Total number of deliveries you performed during reporting period: 8
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 8 Birthing Ctr: 2 Hospital: 2 12
F	Number of unplanned: Breech: 0 Twins / Multiples: 0 0	
G	Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0 0	
H	Number of water births: 8	
I	Number of mothers requiring sutures: 0	
3	A	Number of mothers transferred antepartum (for medical reasons): 2 0
	B	Number of mothers transferred intrapartum: 2 0
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	Planned or Unplanned Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)
12/21/18	SGA	unplanned	35.4	NSVD
11/3/18	PIH	unplanned	32.6	NSVD

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

DATE	REASON FOR TRANSFER	Delivery Method	MOTHER	BIRTH WEIGHT	INFANT	
			Complications?		Admitted to NICU? If yes, reason and # of days	Neonatal Death?
1/2/18	maternal exhaustion	✓	none	8#102	no	no
11/4/18	pain management	✓	none	7#602	no	no

Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	0		
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	0				
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	0					
Total Number of Fetal Death/Stillborn (4-A)						

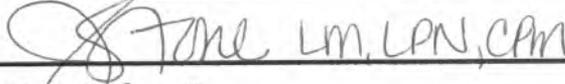
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	0			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Jennifer Stone
Signature:  LM, LPN, CPM
Date Signed: 7-28-18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Isara M^a Verano Sanchez License #: MW 356.
 Practice Name: Global OB/GYN Centers.
 Address: 10067 Pines Blvd. Suite B Perm. Pines, FL 33024
Tel: 954-430-7777
 Phone Number: 561-951-9205 Email: veranoisara@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number						Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:				59	
	B	Total number of maternity clients you accepted for care in the reporting period:				59	
	C	Total number of deliveries you performed during reporting period:				0	
	D	Total number of licensed midwife students assigned to you during the reporting period:				0	
	E	How many delivered at: Home:	<input type="text" value="0"/>	Birthing Ctr:	<input type="text" value="0"/>	Hospital:	<input type="text" value="0"/>
F	Number of unplanned: Breech:	<input type="text" value="0"/>	Twins / Multiples	<input type="text" value="0"/>			0
G	Number of planned VBAC:	# of primary VBAC:	<input type="text" value="0"/>	# of subsequent VBAC:	<input type="text" value="0"/>	0	
H	Number of water births:				0		
I	Number of mothers requiring sutures:				0		
3	A	Number of mothers transferred antepartum (for medical reasons):				0	
	B	Number of mothers transferred intrapartum:				0	
	C	Number of mothers transferred postpartum: (medical reasons)				0	
	D	Number of newborn transfers:				0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)				0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)				0	
	C	Number of maternal deaths: (please submit separate report)				0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

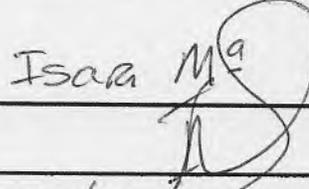
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Isara M^a Verano Sanchez

Signature: 

Date Signed: 07/20/2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Michele D'Angelo License #: MW 357
 Practice Name: Birth & Wellness Center of Gainesville
 Address: 607 E University Ave
Gainesville FL 32601

Phone Number: 352-372-4784 Email: michelec.dangelo@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					13
	B	Total number of maternity clients you accepted for care in the reporting period:					13
	C	Total number of deliveries you performed during reporting period:					6
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:	3	Birthing Ctr:	3	Hospital:	0
	F	Number of unplanned: Breech:	0	Twins / Multiples	0		
	G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	0	
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					2
3	A	Number of mothers transferred antepartum (for medical reasons):					1
	B	Number of mothers transferred intrapartum:					1
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Michele D'Angelo
 Signature: 
 Date Signed: 7/23/2018

Mail completed forms to:
 Florida Department of Health
 Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Kitty Lakey, LM., CPM. **License #:** MW 358
Practice Name: Sweet Child O' Mine
Address: 215 Litha Pinecrest Road
Brandon, Fl. 33511
Phone Number: 1-813-685-8404 **Email:** kittylakey.lm.cpm@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II, CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					13	
	B	Total number of maternity clients you accepted for care in the reporting period:					13	
	C	Total number of deliveries you performed during reporting period:					14	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	1	Birthing Ctr:	13	Hospital:	0	14
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
G	Number of planned VBAC:	# of primary VBAC:	0	# of subsequent VBAC:	1			1
H	Number of water births:					11		
I	Number of mothers requiring sutures:					1		
3	A	Number of mothers transferred antepartum (for medical reasons):					1	
	B	Number of mothers transferred intrapartum:					4	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C) 0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGAR5	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D) 0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A) 0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

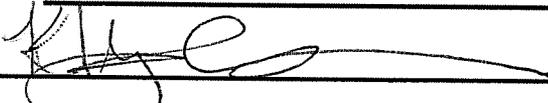
Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0	
Total Number of Maternal Deaths (4-C)		0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Kitty Lakey, LM., CPM.

Signature: 

Date Signed: 07/11/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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Council of Licensed Midwifery
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 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Jessica Willison License #: 359
 Practice Name: Orange Blossom Midwifery, LLC, Sweet Baby Midwifery, The Birth Place
 Address: 2830 Plaza Terrace Dr. Orlando, FL 32803
 Phone Number: 352-559-2958 Email: jessica.willison@orangeblossommidwifery.com
Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: <u>4</u>
	B	Total number of maternity clients you accepted for care in the reporting period: <u>4</u>
	C	Total number of deliveries you performed during reporting period: <u>11</u>
	D	Total number of licensed midwife students assigned to you during the reporting period: <u>0</u>
E	How many delivered at: Home: <u>8</u> Birthing Ctr: <u>3</u> Hospital: <u>0</u>	
F	Number of unplanned: Breech: <u>0</u> Twins / Multiples: <u>0</u>	
G	Number of planned VBAC: # of primary VBAC: <u>0</u> # of subsequent VBAC: <u>0</u>	
H	Number of water births: <u>5</u>	
I	Number of mothers requiring sutures: <u>1</u>	
3	A	Number of mothers transferred antepartum (for medical reasons): <u>1</u>
	B	Number of mothers transferred intrapartum: <u>0</u>
	C	Number of mothers transferred postpartum: (medical reasons) <u>1</u>
	D	Number of newborn transfers: <u>0</u>
4	A	Number of fetal deaths / stillborn: (midwife delivery only) <u>0</u>
	B	Number of fetal deaths / neonatal: (within seven days of birth) <u>0</u>
	C	Number of maternal deaths: (please submit separate report) <u>0</u>

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
4/18	2nd/3rd degree laceration for repair	< 10 ^{hrs}	Lac. Repaired & AS changed

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
			/		
			/		
			/		
			/		
			/		
			/		
			/		
			/		

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Jessica A. Willison, L.M., CPM
Signature: *Jessica A. Willison*
Date Signed: 7/31/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



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ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Zael Prieto License #: MW 360
 Practice Name: _____
 Address: 4410 SW 162 Plac
Miami FL 33185
 Phone Number: (786) 546 3976 Email: zaelprieto@yahoo.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care: 0
	B	Total number of maternity clients you accepted for care in the reporting period: 0
	C	Total number of deliveries you performed during reporting period: 0
	D	Total number of licensed midwife students assigned to you during the reporting period: 0
	E	How many delivered at: Home: 0 Birthing Ctr: 0 Hospital: 0
F	Number of unplanned: Breech: 0	Twins / Multiples: 0
	Number of planned VBAC: 0 # of primary VBAC: 0	# of subsequent VBAC: 0
H	Number of water births: 0	
I	Number of mothers requiring sutures: 0	
3	A	Number of mothers transferred antepartum (for medical reasons): 0
	B	Number of mothers transferred intrapartum: 0
	C	Number of mothers transferred postpartum: (medical reasons) 0
	D	Number of newborn transfers: 0
4	A	Number of fetal deaths / stillborn: (midwife delivery only) 0
	B	Number of fetal deaths / neonatal: (within seven days of birth) 0
	C	Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Zael Piacito
Signature: [Handwritten Signature]
Date Signed: 07/29/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

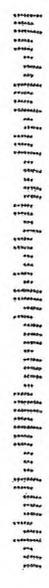
Zael Prieto
440 SW 112 Place
Miami FL 33185

MIAMI FL 331
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Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way
Bin # C-06
Tallahassee, FL 32399-3256

32399-325699



**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: KellyAnne Jaber License #: MW 361
 Practice Name: First Coast Midwifery Services
 Address: 7117 Blache Ct Jacksonville, FL 32210
7117 Blache Ct Jacksonville, FL 32210
 Phone Number: (904) 990-3619 Email: KJaber1017@gmail.com

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)	
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):					4	
	B	Total number of maternity clients you accepted for care in the reporting period:					4	
	C	Total number of deliveries you performed during reporting period:					3	
	D	Total number of licensed midwife students assigned to you during the reporting period:					0	
	E	How many delivered at: Home:	3	Birthing Ctr:	0	Hospital:	0	3
	F	Number of unplanned: Breech:	0	Twins / Multiples	0			0
	G	Number of planned VBAC:	# of primary VBAC:	1	# of subsequent VBAC:	0		1
	H	Number of water births:					1	
	I	Number of mothers requiring sutures:					0	
3	A	Number of mothers transferred antepartum (for medical reasons):					0	
	B	Number of mothers transferred intrapartum:					1	
	C	Number of mothers transferred postpartum: (medical reasons)					0	
	D	Number of newborn transfers:					0	
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0	
	B	Number of fetal deaths / neonatal: (within 7 days of life)					0	
	C	Number of maternal deaths: (please submit separate report)					0	

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
6/12/18	Retained placenta	2	D&C, IV abx/ stable
Total Number of Postpartum Transfers from all sheets (3-C)			1

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						0

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	0

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: KellyAnne Jaber

Signature: *KellyAnne Jaber*, LM, CPM

Date Signed: 7/24/18

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Tanashia R Huff **License #:** 362
Practice Name: Midwife Tanashia Huff
Address: 5575 Lily Pond Ct
Tallahassee, FL 32303
Phone Number: 850.525.6291 **Email:** MidwifeTanashia@gmail.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing.

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number							Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:					0
	B	Total number of maternity clients you accepted for care in the reporting period:					0
	C	Total number of deliveries you performed during reporting period:					0
	D	Total number of licensed midwife students assigned to you during the reporting period:					0
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:	0
	F	Number of unplanned: Breech:		Twins / Multiples			0
	G	Number of planned VBAC:	# of primary VBAC:		# of subsequent VBAC:		0
	H	Number of water births:					0
	I	Number of mothers requiring sutures:					0
3	A	Number of mothers transferred antepartum (for medical reasons):					0
	B	Number of mothers transferred intrapartum:					0
	C	Number of mothers transferred postpartum: (medical reasons)					0
	D	Number of newborn transfers:					0
4	A	Number of fetal deaths / stillborn: (midwife delivery only)					0
	B	Number of fetal deaths / neonatal: (within seven days of birth)					0
	C	Number of maternal deaths: (please submit separate report)					0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
	N/A		
Total Number of Postpartum Transfers from all sheets (3-C)			0

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
	N/A				
Total Newborn Transfers from all sheets(3-D)					0

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
	N/A					
Total Number of Fetal Death/Stillborn (4-A)						0

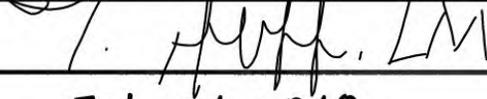
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	N/A			
Total Number of Fetal/Neonatal Deaths (4-B)				0

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	0	
Total Number of Maternal Deaths (4-C)		

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Tanashia R Huff
Signature: 
Date Signed: July 21, 2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

**FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery**

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: Elena Rosa, LM, CPM, LMT License #: MW363
 Practice Name: Beautiful Birthings
 Address: 1206 Chelsea Place
Orlando, FL 32803
 Phone Number: 407-920-0405 Email: erosa@midwiferyschool.org

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number	Total(s)
2	A Total number of initial OB clients seen by you (include those accepted into care and not accepted into care): 0
	B Total number of maternity clients you accepted for care in the reporting period: 1
	C Total number of deliveries you performed during reporting period: 2
	D Total number of licensed midwife students assigned to you during the reporting period: 0
	E How many delivered at: Home: 2 Birthing Ctr: 0 Hospital: 0 2
	F Number of unplanned: Breech: 0 Twins / Multiples: 0 0
	G Number of planned VBAC: # of primary VBAC: 0 # of subsequent VBAC: 0 0
	H Number of water births: 0
	I Number of mothers requiring sutures: 1
3	A Number of mothers transferred antepartum (for medical reasons): 0
	B Number of mothers transferred intrapartum: 0
	C Number of mothers transferred postpartum: (medical reasons) 0
	D Number of newborn transfers: 0
4	A Number of fetal deaths / stillborn: (midwife delivery only) 0
	B Number of fetal deaths / neonatal: (within 7 days of life) 0
	C Number of maternal deaths: (please submit separate report) 0

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

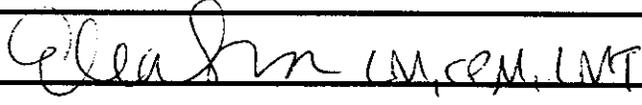
(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: Elena Rosa, LM, CPM, LMT
Signature: 
Date Signed: 07/28/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MQA.Midwifery@FLHealth.gov

FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
 MOA Midwifery@FLHealth.gov

HEALTH

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: JOSE SANCHEZ License #: MW 364
 Practice Name: NOT PRACTICING
 Address: 11501 NW 59th Street APT 108 DUAL
FL 33178
 Phone Number: 305-778-1355 Email: SANCHEZANDRAVE@Sguel.com

Email addresses are public records. If you do not want your email address released pursuant to a public records request do not provide an email address or send electronic mail to the Department and contact the Department by telephone or in writing

SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (Include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
E	How many delivered at: Home:	Hospital:
	Birthing Ctr:	
F	Number of unplanned: Breech:	# of subsequent VBAC:
	Twins / Multiples	
G	Number of planned VBAC: # of primary VBAC:	
H	Number of water births:	
I	Number of mothers requiring sutures:	
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
	NA			
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached

Total Number of Maternal Deaths (4-C)

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name:

JOSE SANCHEZ SOSA

Signature:

[Handwritten Signature]

Date Signed:

07/30/2018

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4062 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
MOA-Midwives@FLHealth.gov



FLORIDA DEPARTMENT OF HEALTH (DEPARTMENT)
Council of Licensed Midwifery
 4052 Bald Cypress Way, Bin #C-06
 Tallahassee, FL 32399-3256
MQA.Midwifery@FLHealth.gov

ANNUAL REPORT OF MIDWIFERY PRACTICE

Report data from July 1 through June 30 of each year. Reports are due no later than July 31.

SECTION I: PRACTICE INFORMATION

Midwife Name: _____ License #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Email: _____

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SECTION II. CLIENT CARE SERVICES FOR THE MIDWIFE (include data for the report year only)

Section number		Total(s)
2	A	Total number of initial OB client visits. Include both clients accepted for care and those clients initially seen but not accepted into your care:
	B	Total number of maternity clients you accepted for care in the reporting period:
	C	Total number of deliveries you performed during reporting period:
	D	Total number of licensed midwife students assigned to you during the reporting period:
	E	How many delivered at: Home: _____ Birthing Ctr: _____ Hospital: _____
	F	Number of unplanned: Breech: _____ Twins / Multiples: _____
	G	Number of planned VBAC: # of primary VBAC: _____ # of subsequent VBAC: _____
	H	Number of water births:
	I	Number of mothers requiring sutures:
3	A	Number of mothers transferred antepartum (for medical reasons):
	B	Number of mothers transferred intrapartum:
	C	Number of mothers transferred postpartum: (medical reasons)
	D	Number of newborn transfers:
4	A	Number of fetal deaths / stillborn: (midwife delivery only)
	B	Number of fetal deaths / neonatal: (within seven days of birth)
	C	Number of maternal deaths: (please submit separate report)

(3-C) MATERNAL POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge
Total Number of Postpartum Transfers from all sheets (3-C)			

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome
Total Newborn Transfers from all sheets(3-D)					

SECTION IV - DEATHS

(4-A) STILLBIRTH (midwife delivered only)

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		
Total Number of Fetal Death/Stillborn (4-A)						

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of birth following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
Total Number of Fetal/Neonatal Deaths (4-B)				

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the state of Florida. The information I have given is accurate and true.

Printed Name: _____
Signature:  _____
Date Signed: _____

Mail completed forms to:
Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

or

Email to:
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