

# D Form: Professional Reference and Clinical Experience

## FOR UBC'S INTERNATIONALLY EDUCATED MIDWIVES BRIDGING PROGRAM

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### BACKGROUND INFORMATION

The applicant indicated below in Part I has applied to participate in the Internationally Educated Midwives Bridging Program (IEMBP) with an intention of registering to practice midwifery in Canada. This pre-registration bridging program is designed to assist internationally-educated midwives to “bridge” or address gaps in their knowledge or skills as they apply to midwifery practice in Canada.

The IEMBP assessors will use the information in this form when they are deciding whether this applicant is eligible for entry to the IEMBP. One of the ways to qualify for the IEMBP includes proof of past or current registration as a midwife in a regulated jurisdiction. Also, IEMBP applicants must provide evidence of their identity and proof that they are ethical, safe and responsible practitioners.

If this applicant completes the IEMBP and applies for midwifery registration in Canada, the midwifery regulatory organization (the organization that regulates the profession of midwifery in the public interest) in that province or territory will also use the information in this form to make their registration assessment decision. Sharing your knowledge of this applicant through completion of this form is important for making these assessments.

### INSTRUCTIONS FOR REFEREE

**\*NOTE: If you are unable to submit this for electronically, please print the application form and the digital photo and follow the instructions below. The applicant has authorized you to provide this confidential information and understands that any information you provide will not be disclosed to the applicant.**

1. Sign the section verifying that the photo is a true likeness of the applicant (or sign the back of the photo for paper copies).
2. Fully complete Part II of this reference form. Attach extra pages, if necessary.
3. Provide your name, contact information, professional designation, and registration/license number in the designated box at the end of the reference form. This information is crucial. We may contact you for further information.
4. Sign the reference form in the place indicated.
5. Email copy of document to the UBC Midwifery IEMBP at [iembp.admissions@ubc.ca](mailto:iembp.admissions@ubc.ca)
6. If submitting by post, seal the completed reference form in an envelope and sign your name across the seal. **Please send it directly to the program and do not give it to the applicant.** The address

is:

IEMBP Admissions  
UBC Midwifery Program, Faculty of Medicine  
201 - 13737 96th Avenue (City Centre 1)  
Surrey, BC, Canada  
V3V 0C6

Thank you very much for your assistance in providing this important information. We appreciate your time and effort.

# D Form: Professional Reference and Clinical Experience

## FOR UBC'S INTERNATIONALLY EDUCATED MIDWIVES BRIDGING PROGRAM

### INSTRUCTIONS TO APPLICANT

Please complete Part I and send a copy of this form to each of your Referees.

### PART I (to be completed by the applicant)

Full name of Applicant  
(first, last name)

Name of Referee:  
(first, last name)

Indicate the referee's professional designation:

Name of Midwifery Regulatory Organization:

Student Number, if any:

Date of Graduation:

I authorize the midwifery regulatory organization named above to disclose to the Internationally Educated Midwives Bridging

Program (IEMBP) information and the regulatory organization in the province of British Columbia in Canada that is otherwise confidential. I agree that communication between persons in these organizations pertaining to my application to the IEMBP shall be privileged and I waive any right of disclosure to me of the same.

Applicant Signature:

Date:

Passport  
photo of  
applicant

I certify that this  
is a true likeness  
of the applicant

Signature  
box

**PART II (to be completed by the Referee)**

1. In what role were you when you observed this applicant working as a midwife?

2. Where did you observe this applicant working as a midwife?

3. During what period of time did you observe this applicant working as a midwife? (please give years and specific dates if possible)

4. Have you directly observed the applicant conduct deliveries on their own responsibility?

YES  NO

5. If you are a physician, has the applicant referred clients in their care to you for consultation or transfer of care?

YES  NO  NOT APPLICABLE

6. Did the applicant provide prenatal (antenatal) care? Please describe

7. Did the applicant provide postpartum care? Please describe.

8. Did the applicant provide care to the newborn? If so, for how long (eg day of birth only, for 6 weeks postpartum)

9. To your knowledge, does the applicant have any mental health issues, or substance abuse problems that would impair their ability to practice as a midwife?

YES  NO

10. If Yes, please explain:

11. Are you aware of any complaints regarding the applicant, which have resulted in an investigation or disciplinary proceeding?

YES       NO

12. If Yes, please explain:

13. Do you consider this applicant to be honest, trustworthy, and ethical?

YES       NO

If No, please, explain:

14. Do you believe that this applicant conducts themselves with appropriate professional behavior?

YES       NO

If No, please, explain:

15. Do you believe the applicant practices midwifery safely?

YES       NO

If No, please, explain:

16. Do you have any additional information with respect to the applicant's professional or ethical conduct you believe should be disclosed to the IEMBP?

YES       NO

If Yes, please explain:

17. Further comments?

### PART III – Clinical Experience (to be completed by referee)

We are aware that you may only be able to verify some of this applicant's experience. The applicant will be submitting additional evidence of their midwifery experience. In this form, **please only verify births that you have seen or directly supervised, or for which you have access to related records at your institution or practice.** Please fully complete Part II below. Attach extra pages, if necessary.

*Please be as specific as possible with dates. If you can verify clinical experience from several non-consecutive time periods, please list them separately.*

For example: May 2001 - April 2002 St. Andrew's Hospital

Sept 2003 - March 2004 St. Andrew's Hospital

The births that I am verifying took place in the following date(s) and location(s):		
From (month/year)	To (month/year)	Practice or Clinical Site Name and Location

**Part of the IEMBP's assessment of clinical practice is to determine the applicant's overall amount of clinical experience and also the applicant's recent or current experience. In order to assist this determination please complete the following tables:**

#### Primary/Principal Midwife

*The primary (principal) midwife is a midwife with complete, non-delegated, responsibility for the care of a woman and her newborn. The primary midwife is normally responsible for managing the labour and delivery and for the immediate care of the newborn. In cases where complications arise, the primary midwife makes the decision to transfer care, coordinates the transfer, collaborates with the health professional to whom she has referred her client, and provides supportive care after the transfer occurs. Supervised student midwives who act in the role of primary midwife are also included in this definition.*

#### Other Midwife

*The other midwife is a midwife acting in a role other than Primary Midwife.*

#### Continuity of Care

*Applicants have provided continuity of care to a single client, if they have met with the client prior to the birth, attended the birth and had at least one visit post partum.*

#### Out-of-hospital birth

*A birth conducted by a midwife in a setting without on-site surgical (cesarean section) and/or anesthetic (epidural) capabilities. Such sites may include homes, birth centres, nursing stations and some hospitals.*

Year	Numbers of births out of hospital birth	Numbers of births in Hospital	Numbers of continuity of Care

**Previous to 10 years:**

The numbers are based on:  actual records  estimates

Name of the person filling out this form: (First name, Last name)

Professional Designation:

License/Registration number:

Address:

Telephone No.:

Email Address:

Signature:

Date: