Medical Certificate

This form is to be completed by a registered Medical Practitioner. It should be sent to the Midwifery Council directly by the Medical Practitioner by email to health@midwiferycouncil.health.nz

This medical certificate is given in support of an application to be entered onto the New Zealand Register of Midwives. Section 16(d) of the Health Practitioners Competence Assurance Act 2003 provides that the Midwifery Council shall not register any person as a midwife if it is satisfied that the person is unable to perform the functions required of a midwife because of some mental or physical condition.

Applicant Details	
Title/Position	
Given Name(s)	
Family Name	

Applicant declaration

I .....
(enter name)

	Yes	***No***
Declare that I suffer from no physical or mental condition or disability that could adversely affect my ability to practise as a midwife that I have not fully disclosed to the Midwifery Council		
I consent to the Medical Practitioner releasing the results of this examination to the Midwifery Council.		

Signature	
Date	

Te Tatau o te Whare Kahu | Midwifery Council
Level 5, 22–28 Willeston Street, Wellington 6011
PO Box 9644, Marion Square, Wellington 6141
Phone: +64 4 499 5040
Email: health@midwiferycouncil.health.nz
Website: www.midwiferycouncil.health.nz

Medical Practitioner to Complete

..... attended my clinic/practice on ____/____/____

(named applicant) *(date)*

I have completed my examination of the applicant an

☐...have not found any condition that I feel should be brought to the Midwifery Council's attention

Or

☐...my examination indicated the following conditions which could have an effect on the applicant's ability to practise as a midwife:

Comment if required:

Medical Practitioners details	
Name	
Phone	
Email	
Practice Address	
Signature	
Date	

Stamp here

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