Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Certified Nurse Midwives Adverse Occurrence Report

1. As set forth in 68 IAC 1300.490, certified nurse midwifes are required to complete this report for the following certified nurse midwife adverse occurrences:
   1.) The death of a neonate under the licensee's care within 48 hours of delivery or attempted delivery, not including a still birth or miscarriage;
   2.) The death of a pregnant or postpartum patient under the licensee's care within 48 hours of delivery or attempted delivery;
   3.) The in-patient emergency hospitalization of a neonate under the licensee's care within 48 hours of delivery or attempted delivery; or
   4) The in-patient emergency hospitalization of a patient under the licensee's care within 48 hours of delivery or attempted delivery.
2. Email complete signed forms to FPR.CIU@Illinois.gov within the following time frames:
   a. 24 hours after each adverse occurrence that involves the death of a neonate or patient. or
   b. 14 days after each adverse occurrence that involves the in-patient emergency hospitalization of a neonate or patient.
   c. In the event that a licensee does not have knowledge or cannot reasonably be expected to have knowledge, but subsequently obtains actual knowledge of an adverse occurrence, then such licensee shall file an adverse occurrence report within 24 hours after obtaining knowledge of the death of a neonate or patient or within 14 days after obtaining knowledge of the in-patient emergency hospitalization of a neonate or patient.

Midwife Name:	License No.:
Midwife Email:	Midwife Phone No.:
Midwife Address, City, State, Zip Code: ☐ *check if address changed*	

CERTIFIED NURSE MIDWIFE ADVERSE OCCURRENCE INFORMATION

Date & Time of Occurrence:
Facility Name and Address where Occurrence Took Place:
Name and Date of Birth of Patient:
Midwife Procedure Involved:
Type and dosage of sedation or anesthesia utilized in the procedure:
Name and Address of Hospital patient sought treatment. Please include date and time of treatment if known.
Description of occurrence (please note whether a death, permanent organic brain dysfunction, or hospitalization of a patient occurred): *Please use additional pages if needed.*

CERTIFICATION

Under penalty of perjury, as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, I herein certify that this Dental Adverse Occurrence Report and the information herein are true and accurate. Failure to provide such a report to the Division shall be grounds for discipline as set forth in 225 ILCS 25/23.

Signature:	Date: