DEPARTMENT OF HEALTH

Request to be Designated as a Doula Certification Organization

HEALTH REGULATION DIVISION

Notice to Doula Certification Organizations

The Minnesota Department of Health (MDH) will review this request to determine if your organization satisfies the minimum criteria for designation as a doula certification organization. If MDH determines that the criteria are satisfied, then the organization will be designated as a doula certification organization under Minn. Stat. § 148.9965. The organization will then be listed in the State Register and on the Department of Health website. Note that this designation is based on the department's assessment of the above noted information and does not constitute an endorsement of the services provided by the organization.

In accordance with Minnesota Statutes, Sec. 13.41 MN Statutes (https://www.revisor.mn.gov/statutes/cite/13.41), all data submitted on this form shall be classified as public information upon designation as a doula certification organization.

Please provide the information in each section below; all fields are required. If you have any questions about the information being requested, please contact the Health Regulation Division at the address and phone number provided below.

Organization

Name of Organization: ____

Address: ____

City: ____

County: ____

State: ______________________________ Phone: ______________________________

Zip: ______________________________ Fax: ______________________________

Website: ____

Permanent Email Address: ____

The organization's email address provided needs to be permanent. The Health Regulation Division will use this email address to communicate information related to your status as a Doula Certification Organization. Please contact the Health Regulation Division at the address below if you need to change your information.

State Tax ID: ____

Federal Tax ID: ____

Is the organization: (check one):

- ☐ For-profit
- ☐ Non-profit
- ☐ Tribal (Specify Nation: _______________________)

Type of organization: (check one)

- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ LLC
- ☐ Trust
- ☐ Other: ____________________________________

Ownership

Owner/Operator Name: ____

Contact information:

Address: ____

Phone: ____

Email Address: ____

Officer/Agent Name: ____

Officer/Agent Title: ____

Contact Person (if different from above): ____

Contact Person Title: ____

Certification and Professional Standards

Type of Doula Certification: (check all that apply)

- ☐ Antepartum
- ☐ Birth
- ☐ Postpartum
- ☐ Other: ___________________________________

Length of initial doula certification: ________ months

Recertification required after: ________ months

Continuing Education Requirements (CEUs): (check one)

- ☐ Yes

  Fill in required number of CEUs per time period: ________ per ________

- ☐ No

Program Information

The organization must have all items below in order to qualify as an MDH-approved Doula Certification Organization.

Do you have the following? (Check one for each question)

1. Professional standards
   - ☐ Yes
   - ☐ No
2. Scope of practice
   - ☐ Yes
   - ☐ No
3. Code of ethics
   - ☐ Yes
   - ☐ No
4. Statement of non-discrimination
   - ☐ Yes
   - ☐ No
5. Grievance procedure for clients, providers, or others
   - ☐ Yes
   - ☐ No

Attestation and signature

I declare that the above information is true and accurate to the best of my knowledge.

Signature: ____

This form can be signed electronically using the free Adobe Acrobat program. If you do not wish to sign electronically, you can print this form, sign it, and then send a scanned copy to the email address below.

Name (please print): ____

Title: ____

Date: ____

Submission

Email the completed form to health.hop@state.mn.us

Minnesota Department of Health
Health Occupations Program
P.O. Box 64882
St. Paul, Minnesota 55164-0882
Telephone: 651-201-4200
health.hop@state.mn.us
www.health.state.mn.us/doula

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To obtain this information in a different format, call: 651-201-4200.