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Subject:	<b>Restricted Membership &amp; Licensure – Supervised Practice</b>	Issued:	<b>September 2025</b>	
		Revised:		
Distribution:	<b>Members, TC Members, &amp; Employees</b>	Approved:	<b>Transitional Council September 2025</b>	

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## Preface

Restricted membership and licensure is available to a person who:

- has not successfully completed a recognized midwifery education program or an approved assessment process and is not registered as a midwife in another Canadian jurisdiction OR
- has not successfully passed the Canadian Midwifery Registration Examination (CMRE), or an equivalent examination AND
- meets the requirements of section 7 of *The Regulatory Bylaws*; AND
- is working, further to a plan approved by the Council, towards meeting the requirements to enable registration as a full practising member.

A person with a restricted licence must comply with any conditions and restrictions set out in that licence and must practise midwifery under the supervision of a supervisor(s) approved in writing by the Council.

## Components of an Application for Restricted Membership & Licensure (Plan Template Attached)

1. Name and contact information of applicant.
2. Name and contact information of applicant's employer (if applicable).
3. Name, contact information, employer information, credentials and qualifications of proposed supervisor(s).
4. A letter from the applicant's employer (if applicable) confirming agreement with and support for the plan.
5. Identification of the specific requirements the applicant does not meet in order to be eligible for full practising membership and licensure and a description of the steps necessary to meet them, in order to enable registration as a full practising member, including, but not limited to birth numbers, completion of an education program or assessment process, and completion of examination.
6. A timeframe for completion and a schedule that outlines the frequency of monitoring the plan by the supervisor(s).
7. The plan shall include the signatures of the proposed supervisor(s) and the applicant, as well as the applicant's employer (if applicable).
8. The plan shall include the signature of the SCM Registrar upon approval of the plan by the Transitional Council.

## Supervisor Requirements

1. The primary supervisor must be a registered midwife licensed to practice in the province of Saskatchewan with a minimum of two (2) years of practice experience in the full scope of midwifery.
2. Secondary supervisors may be registered midwives, general practitioners where maternity care is part of their practice, obstetricians or other health care providers as deemed appropriate by the Transitional Council. All supervisors must be licensed to practice their profession in the province of Saskatchewan.

Subject: **Restricted Membership & Licensure – Supervised Practice**

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**Supervised Practice Overview**

1. Employers will need to know what they can expect when considering hiring a registered midwife with Restricted Membership & Licensure.
2. Restricted licensure requires that the registered midwife practice under supervision until such time as all deficiencies identified in the Supervision Plan have been remedied to the satisfaction of the approved supervisor and the College.
3. Supervision requirements will differ depending on the deficiencies identified by the registered midwife, the midwifery education program or assessment program, or the College.
4. The supervisor shall monitor the registered midwife's performance and address gaps in knowledge, skills, experience, and abilities.

**Plan Completion**

1. The plan will be considered complete once the approved supervisor(s) and the applicant are in agreement that all requirements have been met and the plan has been signed by the supervisor(s) and the applicant indicating successful completion of all plan requirements.

**Transitional Council Approval Process**

1. In circumstances where an applicant has completed an assessment process that is approved by the Council, but has gaps in her/his knowledge, skills, abilities and/or clinical practice, as determined by information received from the assessment process, other midwifery regulators, referees or other information sources, the Council shall deem the applicant as having not successfully completed the assessment process thereby allowing the applicant to apply for restricted membership and licensure.
2. Upon successful completion of the applicant's plan, the applicant shall submit an original copy of the plan signed by the supervisor(s) and the applicant indicating successful completion of all plan requirements.
3. The plan shall be reviewed by the Council at their next regularly scheduled meeting to determine the applicant's eligibility for full practising membership and licensure or the necessity for continued supervision. If all plan requirements have been met to the satisfaction of the Council, the restricted member may be approved to advance to the full practising category of membership and licensure.

**Supervision Plan**  
**RESTRICTED MEMBERSHIP & LICENSURE**

**Start Date:** \_\_\_\_\_ **Anticipated Completion Date:** \_\_\_\_\_

**Applicant**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_  
Home Work Cell/Pager

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

**Applicant Employer**

Name: \_\_\_\_\_  
Facility RHA Manager

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_  
Home Work Cell/Pager

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

**Supervisor - Primary**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_  
Home Work Cell/Pager

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Employer: \_\_\_\_\_

Credentials/Qualifications: \_\_\_\_\_

**Supervisor - Secondary**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_  
Home Work Cell/Pager

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Employer: \_\_\_\_\_

Credentials/Qualifications: \_\_\_\_\_

Identify the specific requirements you do not meet and/or your deficiencies in clinical knowledge, skills and experience, in order to be eligible for full practising membership and licensure and provide a description of the steps necessary to address them, in order to enable registration as a full practising member.

**1. Requirement/Deficiency:** \_\_\_\_\_

**How this requirement will be met/deficiency will be addressed:** \_\_\_\_\_

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**2. Requirement/Deficiency:** \_\_\_\_\_

**How this requirement will be met/deficiency will be addressed:** \_\_\_\_\_

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**3. Requirement/Deficiency:** \_\_\_\_\_

**How this requirement will be met/deficiency will be addressed:** \_\_\_\_\_

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4. Requirement/Deficiency: \_\_\_\_\_

How this requirement will be met/deficiency will be addressed: \_\_\_\_\_

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5. Requirement/Deficiency: \_\_\_\_\_

How this requirement will be met/deficiency will be addressed: \_\_\_\_\_

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6. Requirement/Deficiency: \_\_\_\_\_

How this requirement will be met/deficiency will be addressed: \_\_\_\_\_

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**AUTHORIZATION - COMMENCEMENT**

We the undersigned have read and agree to this supervision plan.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Employer (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
This plan has been approved by the Transitional Council of the Saskatchewan College of Midwives.

\_\_\_\_\_  
SCM Registrar

\_\_\_\_\_  
Date

**AUTHORIZATION - COMPLETION**

We the undersigned verify that the supervision plan has been successfully completed by the applicant.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Employer (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
The Transitional Council of the Saskatchewan College of Midwives has acknowledged the successful completion of this plan and has approved the applicant for full practising membership and licensure.

\_\_\_\_\_  
SCM Registrar

\_\_\_\_\_  
Date