







**10. PROFESSIONAL DETAILS:** Tick one or more of these boxes:

- |   |   |
|---|---|
| <input type="checkbox"/> IBCLC  | <input type="checkbox"/> Health Visitor                                     |
| <input type="checkbox"/> Bachelor of Nursing or similar university degree     | <input type="checkbox"/> Enrolled Nurse or Mothercraft Nurse                |
| <input type="checkbox"/> Registered Nurse (including NZ Plunket Nurse)        | <input type="checkbox"/> Dietician, Occupational, Speech or Physiotherapist |
| <input type="checkbox"/> Registered Midwife                                   | <input type="checkbox"/> Medical Practitioner                               |
| <input type="checkbox"/> Child & Family Health Nurse or similar qualification | <input type="checkbox"/> Accredited mother support counsellor/leader        |
| <input type="checkbox"/> Other (please describe)                              |   |

Please tick **one** only of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Doctoral Degree in | <input type="checkbox"/> Graduate Diploma in                         |
| <input type="checkbox"/> Master's Degree in | <input type="checkbox"/> Tertiary Diploma/Registration e.g. RN or RM |
| <input type="checkbox"/> Bachelor Degree in | <input type="checkbox"/> Other (please describe)                     |

**11: TERMS AND CONDITIONS:** Please read the following statements carefully; and then sign and date at the bottom of the page. Any disputes arising hereunder will be settled in a court of law in Fairfax County, Virginia, USA. **Failure to sign and date at the bottom of this page will delay processing of your application and result in additional fees.**

**I WISH TO APPLY** to sit for the IBLCE Certification Examination for lactation consultants. I acknowledge that the exam is held only on one date each year (the last Monday in July) and offered in a multiple-choice format only.

**I CERTIFY THAT** the information provided in and with this application is correct and includes all relevant information.

**I UNDERSTAND THAT** my application may be audited. If my application is audited, I will be required to provide sufficient information to prove my eligibility. I also understand that if the information and documentation I provide is not sufficient, I will not be permitted to take the exam.

**I AGREE TO** the IBLCE's exam fees, closing dates for applications and all policies, all as outlined in the current Exam Application Guide, the current Application Supplement and current Exam Payment Form specific to my country. I understand that I will be subject to consequences if I fail to comply with these policies.

**I AGREE THAT,** if I successfully pass the examination, my name will become a part of the list of certificants, and that the IBLCE reserves the right to provide verification of certified individuals in the interests of public protection.

**I AGREE TO** be governed by the Code of Ethics for International Board Certified Lactation Consultants during the period of my certification and to be governed by the IBLCE Disciplinary Procedures for any violations of the Code of Ethics for International Board Certified Lactation Consultants. Furthermore, should an ethics complaint be filed against me, I understand that I have a duty to participate in and cooperate with the disciplinary process. (Please refer to [www.iblce.edu.au](http://www.iblce.edu.au) for a copy of the Code of Ethics and the IBLCE Disciplinary Procedures).

**I KNOWINGLY AND INTENTIONALLY WAIVE** any rights I have under applicable law to request, review or receive any specific information regarding the wording or content of a question or the image or content of a photograph which is part of the IBLCE exam item bank, since I understand that IBLCE must keep this information confidential in order to preserve the integrity of the exam process.

**I AGREE THAT,** after reviewing this application and accompanying documentation, the IBLCE may make additional inquiries as it deems appropriate to verify the information I have provided and to ascertain my character and fitness to engage in the practice of lactation consultation. I understand that I may be disqualified on the basis of conduct that is immoral, unprofessional, dishonest, or contrary to fitness to practice as a lactation consultant.

**I UNDERSTAND THAT** the IBLCE considers satisfactory mental health to be a prerequisite for certification, including the current absence of an untreated, uncontrolled mental illness that impairs or limits an applicant's ability to practice as a lactation consultant in a competent and professional manner, and the unlikelihood of a relapse of any such prior mental illness.

**I UNDERSTAND THAT** the primary way in which the IBLCE staff will communicate with me is through email. Accordingly, I understand that the IBLCE respects the privacy of individuals and has implemented a privacy policy to ensure that the IBLCE collects, processes, and uses personal information in a manner that conforms to the highest standards. (This Privacy Policy is available at [www.iblce.edu.au](http://www.iblce.edu.au))

**I AGREE THAT** any disputes arising hereunder will be settled in a court of law in Fairfax County, Virginia USA.

**Please answer all four questions below by TICKING the appropriate box.**

*If you answer "Yes" to any question, please attach a signed letter describing the circumstances, and explain the current status of the situation. If medical or psychological, please provide IBLCE with a signed letter from your health care provider stating that the condition is cured or controlled to the extent that it would not impair your ability to practice as a lactation consultant. If you are involved in litigation, please attach a copy of the Complaint. If more information is needed, the IBLCE will confidentially seek further information from you.*

**12: SIGNED STATEMENT**

Yes No

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. In the past ten (10) years, have you been, or are you currently, dependent on alcohol, narcotics, drugs, or any other substances that impair or limit, or if the dependency is left untreated is typically likely to impair or limit in the future, physically or mentally, more than only insignificantly your ability to perform the essential duties (see #3 below for a list) of a health care provider, lactation consultant or breastfeeding counselor?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you currently suffer from any severe or chronic illness or disease that specifically impairs or limits, or if left untreated is typically likely to specifically impair or limit, more than only insignificantly your ability to perform any of the essential duties (see #3 below for a list) of a health care provider, lactation consultant or breastfeeding counselor?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been convicted of a crime (including minor traffic offences) that is by its nature specifically related to, or of specific importance for the evaluation of, your ability and trustworthiness to perform any of the essential duties of a health care provider, lactation consultant or breastfeeding counselor? These duties include : (1) the duty to preserve client's/patient's confidences; (2) the duty to act with reasonable diligence; (3) the duty to provide competent service; (4) the duty to maintain personal integrity; (5) the duty to report truthfully and fully to the health care system; (6) the duty to uphold the standards of the lactation consultant profession; (7) the duty to exercise independent professional judgment and to avoid conflicts of interest; (8) the duty to follow IBLCE disciplinary determinations; and (9) the duty to promote, protect and support breastfeeding. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been the subject of a substantiated complaint, for which disciplinary or remedial action was taken, including the revocation of any prior business or professional license , related to your actions, advice, performance or non-performance as a health care provider, lactation consultant or breastfeeding counsel, or other actions in the healthcare field (including but not limited to workplace complaints and complaints before an administrative body, licensing board, professional group, court, mediator, arbitrator or other tribunal)? Or are you   | <input type="checkbox"/> | <input type="checkbox"/> |

**Signature of Applicant** \_\_\_\_\_

**Date** \_\_\_\_\_

Please read this statement carefully, TICK the appropriate response to each of the four (4) questions above and then sign and date this application.