



Doula Attestation

If for any reason you are not able to attest to the following, please provide a detailed explanation on a separate sheet indicating which item cannot be attested to. Please sign the form attesting to the remaining items.

I affirm that I have completed the required minimum training or have the required minimum experience to provide doula services. (Please check the box corresponding with how you intend to demonstrate you meet the qualifications)

Training Pathway:

- Completed a minimum of 16 hours of training which includes all of the following topics:
 - Lactation support
 - Childbirth education
 - Foundations on anatomy of pregnancy and childbirth
 - Nonmedical comfort measures, prenatal support, and labor support techniques
 - Developing a community resource list
- Attestation to training as demonstrated by a certificate of program completion **or** program syllabus.
- Provided support at a minimum of three births

Name of Program: _____

Total Hours Completed: _____

Date Completed: _____

Experience Pathway:

- At least five years of active doula experience in either a paid or volunteer capacity within the previous seven years **AND**
- Attestation to skills in prenatal, labor, and postpartum care as demonstrated by three written client testimonial letters or three professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, DHCS enrolled doula, or community-based organization.
 - Letters must be written within the last seven years.
 - One letter **must** be from either a licensed provider, a community-based organization, or a DHCS enrolled doula.

I further attest that I:

- Am at least 18 years of age
- Have completed Health Insurance Portability and Accountability Act training.
- Possess a valid adult/infant CPR certification
- Have no recent history (10 years) of criminal activity, including a history of criminal activities that endanger Members and/or their families
- Have no history of liability claims
- Have no history of fraud, waste, and/or abuse
- Will support and encourage care in alignment with the American College of Obstetricians and Gynecologists (ACOG) guidelines, including recommended provider visits and vaccinations for the pregnant member and the newborn

Check this box if an explanation(s) accompany this attestation.

I hereby affirm that the information submitted to Partnership HealthPlan of California and any addenda hereto are true, current, and complete to the best of my knowledge and it is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of the Service Agreement.

Applicant Signature
(Signature Stamp Is Not Acceptable)

Printed Name

Date