



**AMERICAN ACADEMY
OF
FERTILITYCARE PROFESSIONALS**

**APPLICATION FOR
INITIAL CERTIFICATION
FOR THE
FERTILITYCARE
MEDICAL CONSULTANT
after completion of the
ST. JOHN PAUL II FELLOWSHIP
in MEDICAL and SURGICAL NAPROTECHNOLOGY
at the ST. PAUL VI INSTITUTE**

Updated October, 2019

This application is for those who have completed the Fellowship within the past year. If it has been over a year, please use the Initial Certification application where you will need to submit cases but not take the exam.

The original application, certificate of medical consultant program completion, attachments and fee payment receipt should be returned to:

Stephen V. Marshall, M.D., CFMCM, CFCP
AAFCP Commission on Certification
FertilityCare Center of Meno, Inc.
200 Terminal Way, Suite 14
Meno, NV 89402
PHONE 775-275-1111
FAX 775-204-1375
EMAIL: certificationfcmcm@aafcp.net

Please either type or print legibly on the application. When possible, you are encouraged to submit your application and related documents electronically in a single PDF file labeled Last name, degree, First name.

Be sure to physically sign at all appropriate places.

The Code of Ethics and Standards for Certification can be reviewed on the AAFCP website
<http://aafcp.net/medical/consultant/certification/>

The Letter of Reference and Statement of Collaborative Relationship with a FertilityCare Practitioner should be sent by their respective author directly to Dr. Marshall.

APPLICATION FEE

\$200 for AAFCP Members and \$300 for Non-AAFCP Members

You may pay the application fee at the AAFCP website <http://aafcp.net/medical/consultant/certification/>

-OR-

you may send a check made out to AAFCP and send to
Jamie Hobor
AAFCP Financial Officer
740 Lynch Circle
Virginia Beach, VA 23455
EMAIL finance@aafcp.net

***Be sure to include a copy of the receipt with your application.**

Enquiries should be addressed to Dr. Marshall.

American Academy of FertilityCare Professionals

Application for Certification for the FertilityCare Medical Consultant after the St. John Paul II Fellowship

APPLICANT:

NAME _____

PLEASE PRINT ADDRESS _____

Street City State Zip

PLEASE PRINT PHONE FAX _____

EMAIL _____

MEDICAL or CLINICAL EXPERIENCE _____

SPECIAL _____

MEDICAL LICENSE State or Province Country and number _____

St. John Paul II FELLOWSHIP completion date Standard 4.0 _____

I. Name of Creighton Model FertilityCare Center for which you are a Medical Consultant

NAME _____

ADDRESS _____

Street City State Zip

PHONE _____

ARE MEDICAL DEVICES BEING USED _____

NAME OF DIRECTOR OF

FERTILITYCARE CENTER _____

II. MEDICAL CONSULTANT PROGRAM ATTENDED : Standard 2.0

NAME _____

ADDRESS _____

Street City State Zip

PHONE _____

PROGRAM

DIRECTOR OF PROGRAM _____

ARE FACILITY COMPLETE _____

MEDICAL COUNCIL APPROVED _____

2. Please submit a copy of your certificate awarded on completion of the education program and fellowship, or certification letter. Standard 2.2.

III. CODE OF ETHICS: Standard 1.0

A. I have read and agree to accept and adhere to the Code of Ethics of the American Academy of FertilityCare Professionals Standard 2.

Signature

Date

B. Please request a letter of reference regarding your adherence to the Code of Ethics from an individual in your community who has direct knowledge of your FertilityCare service delivery, to be sent directly to the Chairman, Commission on Certification. It is preferable that the letter be submitted by a CFCP, CFCE or a CFC, and may not be from a relative. Standard 2.2

IV. MEDICAL CONSULTANT ACTIVITIES: Standard 3.0

A. Do you attest that you are providing Creighton Model FertilityCare service

B. Do you understand that Certification, if received, will be only for Creighton Model FertilityCare and medical technology service

Attachments

Attachment #1: Evaluation of Collaborative Relationship with FertilityCare Practitioner

Attachment #2: Letter of reference for Code of Ethics (described in III-B above)

ATTACHMENT #1

**EVALUATION OF COLLABORATIVE RELATIONSHIP WITH A FERTILITYCARE PRACTITIONER
(STANDARD 6.2.2)**

NAME OF APPLICANT _____

This form must be returned to the Academy as part of the application process for certification or renewal of certification as a FertilityCare Medical Consultant. Either Option A or Option B must be completed.

OPTION A

To be used only if the Medical Consultant is a FertilityCare Practitioner and has no other Practitioner for which he or she provides medical consultation for clients. Please submit FertilityCare Practitioner certificate received after completion of an Education Program accredited by the Academy or a letter from your program director.

I hereby certify that I provide the complete service of both a FertilityCare Practitioner and medical support in **NaProTECHNOLOGY** to my patients/client. I do not currently have any other FertilityCare Practitioner for whom I provide significant Medical Consultant service.

Signature of Applicant

Date

OPTION B, PART 1

I understand that the information on this form is required for the evaluation of my application for certification with the Academy. I hereby authorize the FertilityCare Practitioner filling out this form to provide honest information, and I release the Practitioner and the Academy from any and all liability related to the use of the information on this form for the certification process. I understand that this form will be sent by the Practitioner directly to the Academy, and I hereby waive my right to receive the information on this form after it is filled out by the Practitioner.

Signature of Applicant

Date

**AFTER COMPLETING ABOVE INFORMATION, PLEASE FORWARD THIS FORM TO THE FERTILITYCARE
PRACTITIONER, WHO MUST COMPLETE THE NEXT PAGE AND RETURN THIS ENTIRE FORM
DIRECTLY TO Dr. Marsh.**

OPTION B, PART 2

STATEMENT BY FERTILITYCARE PRACTITIONER REGARDING COLLABORATIVE RELATIONSHIP WITH APPLICANT FOR CERTIFICATION AS FERTILITYCARE MEDICAL CONSULTANT

NAME OF APPLICANT FOR CERTIFICATION AS FERTILITYCARE MEDICAL CONSULTANT

NAME OF EVALUATING FERTILITYCARE PRACTITIONER _____

Telephone Number of Evaluating FertilityCare Practitioner _____

Your evaluation of the collaborative relationship you have with the applicant is necessary to complete his or her application for certification. Please rate your relationship with the applicant in the following areas. The applicant will not see this form, so please be frank and complete. You may be contacted by the Academy to clarify or discuss any information you put on this form.

	Satisfactory	Unsatisfactory	Don't Know/Not Applicable
1. The medical consultant accepts referrals of clients from me.			
2. The medical consultant refers patients to me for CrM instruction			
3. The medical consultant communicates back with me in a timely manner about my clients that he or she evaluates or treats medically.			
4. The medical consultant relies on me to work with the client on issues of managing observation and charting.			
5. The medical consultant encourages the client to return to me for follow-up instructional visits in CrM.			
6. The medical consultant supports the couples' right to use the CrM according to their own intentions.			
7. The medical consultant encourages and supports the woman's use of CrM charting for gynecologic health maintenance.			
8. The medical consultant applies NaProTECHNOLOGY in a way that supports my teaching and the couple's use of the CrM.			
9. The medical consultant is responsive to my professional needs regarding the CrM.			
10. The medical consultant supports our FertilityCare Center.			
11. The medical consultant advocates for the CrM in the community and among his or her colleagues.			

PLEASE COMMENT BELOW (or on an additional sheet of paper) on ALL “Unsatisfactory” or “Don’t Know or Not applicable” Items. Please also provide any additional comments that you may wish to make:

PLEASE DO NOT RETURN THIS FORM TO THE APPLICANT! RETURN THIS FORM DIRECTLY TO:

Cherethen V. Marshall, Ph.D., CFMC
AAFCP Commission on Certification
FertilityCare Center of Phoenix, Inc.
200 Terminal Way, Suite 303
Phoenix, AZ 8502
PHONE 775-275-5555
FAX 775-204-3375
EMAIL certificationfcmc@aafcp.net

ATTACHMENT #2
LETTER OF REFERENCE

On behalf of _____, who is a candidate applying for certification as a FertilityCare Medical Consultant, you are requested to write a letter of reference for the candidate. The primary purpose of this letter is to attest the applicant's adherence to the Code of Ethics in his or her practice of medical and/or technology and professional activities.

Please send the letter to:

Wendy V. Marshall, M.D., CFMC
AAFCP Commission on Certification
FertilityCare Center of Plano, Inc.
2000 Terminal Way, Suite 303
Plano, TX 75021
PHONE 775.275.5555
FAX 775.204.3375
EMAIL certificationfcmc@aafcp.net

The letter may be sent by email or regular mail.