



**AMERICAN ACADEMY
OF
FERTILITY*CARE* PROFESSIONALS**

**APPLICATION FOR
RENEWAL OF
CERTIFICATION
FOR THE
FERTILITY*CARE*
MEDICAL CONSULTANT**

Updated February, 2024

The original application, certificate of medical consultant program completion, and attachments 1, 2A, 3, and fee payment confirmation should be returned to: (email attachment as a single PDF file preferred)

Gretchen V. Marsh, D.O., CFCMC, CFCP
AAFCP Commission on Certification
FertilityCare Center of Reno, Inc.
1281 Terminal Way, Suite 114
Reno, NV 89502
PHONE 775-827-5111
FAX 775-204-9375
EMAIL: certificationfcmc@aafcp.net

*Please type or print legibly on the application. You are encouraged to submit application and related documents electronically in a single PDF file labeled: Last name, degree, First name.

*Be sure to sign at all appropriate places.

*The Code of Ethics and Standards for Renewal of Certification can be reviewed on the AAFCP website (<https://aafcp.net/medical-consultant-certification/>)

*Attachments 2-B and 4 should be sent by their respective authors directly to Dr. Marsh.

*Completion of application process is expected by renewal date of 7 years from previous date of certification. Applicant may apply for extensions for 4 months at a time up to 3 times before being placed on the inactive list.

APPLICATION FEE

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

You may pay the application fee at the AAFCP website (<https://aafcp.net/medical-consultant-certification/>)

-OR-

you may send a check made out to “AAFCP” and send to:

Jamie Hobor, CFCP
Finance Officer, AAFCP
740 Lynch Circle
Virginia Beach, VA 23455
EMAIL: finance@aafcp.net

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

Inquiries should be addressed to Dr. Marsh

American Academy of FertilityCare Professionals

Application for Renewal of Certification for the FertilityCare Medical Consultant

UNLESS OTHERWISE SPECIFIED, ALL REQUESTED INFORMATION APPLIES TO
THE CREIGHTON MODEL FERTILITYCARE SYSTEM.

APPLICANT:

NAME: _____

PREFERRED

ADDRESS: _____

(Street)

(City)

(State) (Zip)

PREFERRED

PHONE: () FAX: ()

EMAIL: _____

MEDICAL or CLINICAL DEGREE: _____

SPECIALTY: _____

MEDICAL LICENSE (State or Province/Country and number): _____

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

(If affiliated with more than one Fertility Care Center, please use a separate page to list the additional Centers)

NAME: _____

ADDRESS: _____

(Street)

(City)

(State) (Zip)

PHONE: ()

DATE MEDICAL SERVICES BEGAN: _____

NAME OF DIRECTOR OF

FERTILITYCARE CENTER: _____

II. CURRENT CERTIFICATION:

1. YEAR OF ORIGINAL CERTIFICATION AS MEDICAL CONSULTANT: _____

2. EXPIRATION DATE OF CURRENT CERTIFICATION: _____

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 1.2.1)

(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 CFCS, and may not be from a relative. (Standard 1.2.2)

IV. MEDICAL CONSULTANT ACTIVITIES IN THE LAST 7 YEARS : (Standard 3.0)

- A. Do you attest that you are providing Creighton Model FertilityCare service?
Yes: _____ No: _____
- B. Do you understand that Certification, if received, will be only for Creighton Model FertilityCare and medical NaProTechnology services?
Yes: _____ No: _____
- C. Have you served as NaPro case reviewer for other medical consultants going through the certification process?
Yes: _____ No: _____
- D. Approximately how many patients have you actively managed using NaPro over the past 7 years?
_____ 1-50 _____ 51-100 _____ 101-200 _____ more than 200
- E. Please note whether you are involved in promotion of Naprotechnology through...
_____ Lectures/Talks in the community
_____ Teaching in an Education Program
_____ Other: please describe activity below:
-

F THROUGH H PERTAIN ONLY TO A MEDICAL CONSULTANT WORKING WITH AN AAFCP APPROVED EDUCATION PROGRAM (STANDARD 4.0)

- F. Please identify the name of the Education Program and the core curriculum used. (If you teach in more than one Education Program, please list the name of each Education Program and core curriculum on a separate page.)

NAME OF EDUCATION PROGRAM _____
CORE CURRICULUM: _____

- G. Submit a letter from the Program Director attesting to compliance of the stated core curriculum. (If more than one Education Program, please choose one Program Director to submit the letter)
- H. At the discretion of the Commission on Certification, an evaluation may include an evaluation by an individual approved by the Commission.

Attachments

Attachment #1: List of NaProTechnology Patients

Attachment #2: Evaluation of Collaborative Relationship with FertilityCare Practitioner

Attachment #3: Continuing Education Hours

Attachment #4: Letter of reference for Code of Ethics (described in III-B above)

ATTACHMENT #1

LIST OF NAPROTECHNOLOGY PATIENTS

(Assessment 5.2.3) This form, or a document with the same information and signature, must be returned to the Academy as part of the application process for certification or renewal of certification as a FertilityCare Medical Consultant.

NAME OF APPLICANT _____

* Please submit 5 patients seen within the last 5 years. You do not need to submit more than 5 patients. Please select 5 patients for whom you have had direct and detailed professional interaction, and to the extent possible, those with a diversity of medical diagnosis or problems. It is your responsibility to designate the patients with consecutive application numbers (1 through 5) and to be able, upon request of the Academy, to identify and review the records for each patient application number. Under no conditions should you submit to the Academy names or other identifying information (social security numbers, phone numbers, addresses, medical record numbers, etc.) for patients.

CrMS charts should be available for most of the cases you submit. Do not include with the application

ATTACHMENT #1**LIST OF PATIENTS:**

Patient Number	Age	CrMs chart avail.? Yes or No	Diagnosis or Problem for which NaProTECHNOLOGY was applied (may be more than one)	Were you the primary physician (P) or a consultant (C)?	Number of visits/ contacts that you have had with patient and/or Practitioner related to this problem	Brief description of NaProTECHNOLOGY treatments prescribed or recommended (e.g. postpeak progesterone, cervical hyfercation, etc.)	Patient last seen (should not be more than 7yrs from the date of this application)
1							
2							
3							
4							
5							

I certify that the information submitted on this form is accurate and complete to the best of my knowledge.

Signature of Applicant

Date

ATTACHMENT #2

REQUIRED EVALUATION OF COLLABORATIVE RELATIONSHIP WITH A FERTILITYCARE PRACTITIONER (ASSESSMENT 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. Documentation of completion of the FertilityCare Practitioner Education Program is required.

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

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 review the information on this form after it is filled out by the Practitioner.

Signature of Applicant

Date

AFTER SIGNING ABOVE STATEMENT, PLEASE FORWARD THIS FORM TO THE FERTILITYCARE PRACTITIONER, WHO MUST COMPLETE THE NEXT PAGE AND RETURN THIS ENTIRE FORM DIRECTLY TO THE ACADEMY.

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 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.

Please check one response for each of the following statements about your professional relationship with the applicant (medical consultant). (CrM refers to the **Creighton Model FertilityCare™ System**)

	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.			

[illegible]

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

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AAFCP Commission on Certification
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FAX 775-204-9375
EMAIL certificationfcmc@aafcp.net

ATTACHMENT #3

REQUIRED FORM FOR SUBMISSION OF CONTINUING EDUCATION CREDITS IN NAPROTECHNOLOGY® AND THE CREIGHTON MODEL FERTILITYCARE™ SYSTEM.

(Assessments 8.2.1 and 8.2.2) 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. At least 30 hours of acceptable Continuing Education completed within the last 7 years, of which 10 hours should be within the last 3 years, must be documented for certification or renewal of certification.

NAME OF APPLICANT _____

Continuing Education Option	Credit Hours Available	Credit Hours Completed	Date Completed
Attending Annual Meeting of the American Academy of FertilityCare Professionals (AAFCP) Which meetings? _____	See annual meeting brochure or program		
Listening to Recordings from Annual Meeting of the American Academy of FertilityCare Professionals Which Meetings? _____	See annual meeting brochure or program		
Studying the current edition of The Medical and Surgical Practice of NaProTechnology Publication year: _____ Studying the current edition of Reproductive Anatomy and Physiology for the FertilityCare Practitioner Publication year _____ Studying the current edition of Book 1 for the FertilityCare Practitioner Publication year: _____ Studying the current edition of Book 2 for the FertilityCare Practitioner Publication year: _____	5		
Preparing and teaching in an accredited FertilityCare Education Program	15		
Attending Annual Meeting of the International Institute of Restorative Reproductive Medicine Which meetings? _____ Include CME certificate	5		
Attending AAFCP webinars or Regional meetings of MC & Practitioners. Other conferences/webinars/meetings subject to committee approval. Please provide details. _____ _____ _____	5		

I certify that the information submitted on this form is accurate and complete to the best of my knowledge.

Signature of Applicant _____

Date _____

ATTACHMENT #4

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 assess the applicant's adherence to the Code of Ethics of the AAFCP in his or her practice of medical NaProTechnology and professional activities.

Please send the letter to:

Gretchen V. Marsh, D.O., CFCMC, CFCP
AAFCP Commission on Certification
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PHONE 775-827-5111
FAX 775-204-9375
EMAIL certificationfcmc@aafcp.net

The letter may be sent by email or regular mail.