

**CREIGHTON MODEL FertilityCare™ System  
ALLIED HEALTH EDUCATION PROGRAM**

**Program Director – Paul Kortz, RN, MSN, CFCE  
OSF FertilityCare Practitioner Education Program**

**FERTILITYCARE PRACTITIONER**

**Peoria, IL**

**EPI: August 26- September 2, 2017    EPII: February 26– March 3, 2018**

**Directions:**

Fill out application completely. See the last page for mailing instructions and application fees.

**Date** \_\_\_\_\_ **SS#** \_\_\_\_\_

1. **Name (Print)** \_\_\_\_\_  
Last First Middle

2. **Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Sex** \_\_\_\_\_

3. **Home Address** \_\_\_\_\_  
Number and Street (P.O. Box)

\_\_\_\_\_ City State Zip/Postal Code Country

4. **Mailing Address** \_\_\_\_\_  
(If different from home address) Number and Street (P.O. Box)

\_\_\_\_\_ City State Zip/Postal Code Country

5. **Telephone Home** (\_\_\_\_) \_\_\_\_\_ **Work** (\_\_\_\_) \_\_\_\_\_  
(If outside the USA, please indicate country code and city code.)

**Home Fax** (\_\_\_\_) \_\_\_\_\_ **Work Fax** (\_\_\_\_) \_\_\_\_\_  
(If outside the USA, please indicate country code and city code.)

6. **Email** \_\_\_\_\_

7. **Religion** \_\_\_\_\_ 8. **Citizen of** \_\_\_\_\_

9. **Ethnic Origin** \_\_\_\_\_ 10. **Your primary language is:** \_\_\_\_\_

11. **Do you speak a second Language?** Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please identify language \_\_\_\_\_

12. Spouse's Name \_\_\_\_\_  
Last First Middle

13. Number of Children \_\_\_\_\_ Ages: \_\_\_\_\_

14. **EDUCATION HISTORY:** Directions: Give a complete list of **all** educational institutions which you have attended and are currently attending.

<b>NAME OF INSTITUTION</b>	<b>LOCATION</b>	<b>DATES ATTENDED</b>	<b>DIPLOMA/DEGREE</b> (Include the initials of the degree awarded)
High School:		From – To	
Trade or Vocational Schools:		From - To	
College or University:		From - To	
Graduate or Professional:		From - To	
Post Graduate or Professional:		From - To	

**15. OCCUPATIONAL HISTORY:** Directions: Give a complete list of occupations beginning with your most recent. (If never employed outside the home, go directly to question 16).

OCCUPATION/TITLE	LOCATION	DATES EMPLOYED
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a)  
Responsibilities:

Full time \_\_\_\_\_ Part Time \_\_\_\_\_ Reason for leaving \_\_\_\_\_

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OCCUPATION/TITLE	LOCATION	DATES EMPLOYED
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b)  
Responsibilities:

Full time \_\_\_\_\_ Part Time \_\_\_\_\_ Reason for leaving \_\_\_\_\_

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OCCUPATION/TITLE	LOCATION	DATES EMPLOYED
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c)  
Responsibilities:

Full time \_\_\_\_\_ Part Time \_\_\_\_\_ Reason for leaving \_\_\_\_\_

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OCCUPATION/TITLE	LOCATION	DATES EMPLOYED
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d)  
Responsibilities:

Full time \_\_\_\_\_ Part Time \_\_\_\_\_ Reason for leaving \_\_\_\_\_

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16. Have you ever been a Homemaker? Yes \_\_\_ No \_\_\_  
If yes, number of years: \_\_\_\_\_ Full time \_\_\_\_\_ Part Time

17. Have you ever done volunteer work? Yes \_\_\_ No \_\_\_  
Specify:

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## FAMILY PLANNING INVOLVEMENT

18. Have you worked in any of the following capacities in a Natural Family Planning (NFP) Program?

TITLE	YES	NO	FULL OR PART TIME	DATES From - To
Medical Advisor				
Nurse Practitioner				
Program Director				
Teacher Coordinator				
Secretary/Bookkeeper				
Consultant				
Other				

Primarily “paid” or “volunteer”? \_\_\_\_\_

**NOTE: If you answered “No” to all portions of #18, skip #19 – 31.**

19. Where have the NFP Services been provided?

LOCATION	TITLE (See #17)	SPACE RENTED OR DONATED
Private Home		
Public Building		
Church Premises		
Social Agency		
Hospital		
Independent NFP Center		
Public Health Clinic		
Public Family Planning Clinic		
Other		

20. In what method(s) of Natural Family Planning do (did) you commonly provide instruction?

21. What other method(s) of family planning do you (did) you recommend to clients?

22. Which of the following educational formats do (did) you commonly use?

- a. Introductory Lectures
- b. Follow-up Interviews
- c. Phone Advising/Counseling
- d. Correspondence Counseling

If you marked a and/or b, were these individual or group? \_\_\_\_\_

23. Which of the following practices do/did you encourage?

- a. Client continuing with same teacher
- b. Attendance at session(s) by Spouse/partner/fiancé
- c. Conference with other teachers to discuss difficult cases
- d. Referral for medical and/or counseling services when necessary

24. Have you had a physician working with you (at all) in your NFP work? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain the physician's role.

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25. If a physician has worked with you, give name and address of physician.

26. What form of training have you received up to now?

- a. Self-training
- b. Informal training
- c. Semi-formal training
- d. Formal training

27. If informal, semi-formal or formal training received, where and by whom were you trained?

28. What was the duration (in hours or days) of your training?

29. If previously certified, give name(s) of certifying individuals/organization.

30. How useful has your training been?

\_\_\_ Extremely useful    \_\_\_ Useful    \_\_\_ Not Sure    \_\_\_ Little use    \_\_\_ No Use at All

31. In what areas do you feel your training has fallen short of your needs?

- Scientific Basis of the Method(s)
- Psychodynamics of Use of the Method(s)
- Human Sexuality
- Teaching Methodology
- Inservice Training and Supervision
- Study of Use of Method(s) in various circumstances (e.g. breast-feeding, off birth control pill)
- Study of Difficult Cases
- Other (Please specify)

**NOTE: Please complete the following sections - even if you have not previously been involved in NFP.**

32. How important do you consider the following provider attributes on a scale of 1-4?

1 = Absolutely Not Important    2 = Not Important    3 = Important    4 = Very Important

- Female
- Female in reproductive years
- A Natural Family Planning user-acceptor
- A user-acceptor of the NFP method being taught
- Married
- Married with Children
- Well Educated
- Well trained in NFP
- Confident in NFP
- Confident in NFP method being taught
- Willing to refer for psycho-social counseling (e.g. marriage, family)
- Willing to refer for medical problems
- Willing to refer for artificial contraceptive methods

1 = Absolutely Not Important    2 = Not Important    3 = Important    4 = Very Important

- Willing to refer for induced abortion
- Similar social class background to that of client
- Similar age to that of client
- Socially acquainted with clients (e.g. same church, same community)
- A medical orientation
- A family orientation
- Stable in particular vocation
- Open to criticism, failure
- Non-judgmental/supportive
- Friendly/cheerful

33. Please indicate methods of family planning you have used and the length of use of each. (Indicate if combinations of methods used. If used for purposes of monitoring fertility only, please indicate as such.)

Current	_____	Length of Use	_____
2 <sup>nd</sup> Most Recent	_____	Length of Use	_____
3 <sup>rd</sup> Most Recent	_____	Length of Use	_____
4 <sup>th</sup> Most Recent	_____	Length of Use	_____

34. **Satisfaction with use of current method.**

1 = Very Unsatisfied    2 = Unsatisfied    3 = Not Sure    4 = Satisfied    5 = Very Satisfied

Your own evaluation (one number)    \_\_\_\_\_  
Your spouse's evaluation (one number)    \_\_\_\_\_

35. **Confidence with use of current method.**

1 = Very Unconfident    2 = Unconfident    3 = Not Sure    4 = Confident    5 = Very Confident

Your own evaluation (one number)    \_\_\_\_\_  
Your spouse's evaluation (one number)    \_\_\_\_\_

36. **Receptivity to an unplanned pregnancy.**

1 = Very Unreceptive    2 = Unreceptive    3 = Not Sure    4 = Receptive    5 = Very Receptive

Your own evaluation (one number)    \_\_\_\_\_  
Your spouse's evaluation (one number)    \_\_\_\_\_

37. **Reason for use of current method.**

- To Achieve Pregnancy
- To Space Pregnancy
- To Avoid (Limit) Pregnancy
- To Monitor Fertility

**CONFIDENTIAL/PERSONAL INFORMATION**

38. Do you have any physical or mental health condition, with or without accommodation, which in any way impairs your capability to practice or in any way poses a risk of harm to your patients/clients? Yes No

39. In the past five years, have you used any illegal drugs? Yes No

**If you answered “Yes” to questions 38 or 39, please explain completely on a separate sheet of paper and attach to application.**

40. Are you currently free of any illegal drug use? If no, please explain. Yes No

**If you answered “No” to question 40, please explain completely on a separate sheet of paper and attach to application.**

41. Two new organizations, FertilityCare™ Centers of America and FertilityCare™ Centers International, have been introduced. These new organizations are designed to unite CREIGHTON MODEL FertilityCare™ Centers nationwide and worldwide. Please note: any Practitioner or Center must become an affiliate or participate in an affiliated program to order CREIGHTON MODEL FertilityCare™ System teaching materials for client instruction.

**It is important for your understanding of this program that you read, then sign and date the following statement:**

I understand upon completion of the CREIGHTON MODEL FertilityCare™ System Allied Health Practitioner Education Program, in order to purchase CREIGHTON MODEL FertilityCare™ System teaching materials, I will need to become an affiliate or participate in an affiliated program with FertilityCare™ Centers of America or FertilityCare™ Centers International.

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

42. **ESSAY:** Please answer the following question in approximately 500 words on a separate sheet of paper.

“Why is teaching the CREIGHTON MODEL FertilityCare™ System and providing professional FertilityCare services important to me?”  
*(Include in your answer some commentary regarding your motivation for seeking to become a FertilityCare™ Provider, why you have chosen professional training in this system, and the goals you have set for yourself in this work.)*

43. Please attach a **recent snapshot** of yourself to the front of this application.

44. Have **one letter of reference** sent under separate cover directly to the Program Director.

**Your application will be reviewed once all of the following items have been received:**



- \_\_\_1. Completed Application
- \_\_\_2. Arrange for **letter of reference** addressed to Paul Kortz, Program Director and have mailed to:  
Paul Kortz, RN, MSN, CFCE  
8600 Illinois State Route 91  
Peoria, IL 61615
- \_\_\_3. Recent Snapshot
- \_\_\_4. Application Fee - \$25.00 (U.S. Funds only and payable to OSF Medical Group)
- \_\_\_5. Mail the above items to: Same as above

## **IMPORTANT DATES** (Please read carefully)

**June 5, 2017:** It is important to submit your application by this date in order to receive your Advance Packet of information, textbooks and study materials in a timely fashion. Time to review your Advance Packet, read the books, complete the Study Guide and Self Assessment helping you to properly prepare for Education Phase I is highly recommended.

**July 15, 2017:** Applications received after these dates are **not guaranteed a seat** in the current class as **space is limited**.

**August 26 – September 2, 2017:** Class 02 Education Phase I

**February 26- March 2, 2018:** Class 02 Education Phase II

\*Application information will be used for evaluating applicant acceptance, **not** for treatment purposes. The application will be kept as part of the Education Program's academic or continuing education's records.

\*\*Registration is not considered confirmed until application approved,  
\$25 application fee received.