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

# APPLICATION FOR
# INITIAL CERTIFICATION
# FOR THE
# FERTILITY*CARE*
# MEDICAL CONSULTANT

**Updated July, 2019**

**The original application, certificate of medical consultant program completion, and attachments 1, 3, and 4, and fee payment confirmation should be returned to:**

Gretchen V. Marsh, D.O., CFCMC, CFCP
AAFCP Commission on Certification
Fertility*Care* 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. When possible, you are encouraged to submit the 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 (https://aafcp.net/medical-consultant-certification/)

*Attachments 2-B and 5 should be sent by their respective authors directly to Dr. Marsh.

**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:
Becky Knapp, CFCE
Chairman, AAFCP Commission on Certification
2975 N Penstemon Circle
Wichita, KS 67226
EMAIL: **cocchairman.aafcp@gmail.com**

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

Inquiries should be addressed to Dr. Marsh.

# American Academy of Fertility*Care* Professionals

## Application for ***Initial*** Certification for the Fertility*Care* Medical Consultant

**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**

NAME:_____

ADDRESS:_____
(Street) (City) (State) (Zip)

PHONE:__(_____)_____

DATE MEDICAL SERVICES BEGAN:_____
NAME OF DIRECTOR OF
FERTILITYCARE CENTER:_____

**II. MEDICAL CONSULTANT PROGRAM ATTENDED:**(Standard 2.0)

1. NAME:_____

   ADDRESS:_____
   (Street) (City) (State) (Zip)

   PHONE:__(_____)_____
   PROGRAM
   DIRECTOR:_____SUPERVISOR:_____
   DATE SATISFACTORILY COMPLETED
   MEDICAL CONSULTANT PROGRAM:_____

2. Please submit a copy of your certificate awarded on completion of the program, or certification letter. (Standard 2.2.1)

**III. <u>CODE OF ETHICS:</u>** (Standard 1.0)

A. I have read and agree to accept and adhere to the Code of Ethics of the American Academy of Fertility*Care* 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 Fertility*Care* 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. <u>MEDICAL CONSULTANT ACTIVITIES:</u>** (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 Fertility*Care* and medical NaProTechnology services?

Yes:_____ No:_____

**Attachments**

**Attachment #1: List of NaProTechnology Patients**
**Attachment #2: Evaluation of Collaborative Relationship with FertilityCare Practitioner**
**Attachment #3: Observation of the Work of a FertilityCare Practitioner**
**Attachment #4: Continuing Education Hours**
**Attachment #5: 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 Fertility*Care* Medical Consultant.

NAME OF APPLICANT_____

* Please submit 10 patients who were seen within the last 5 years. You do not need to submit more than 10 patients. Please select 10 patients for which 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 10) 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 review for most of the cases you submit***

LIST OF PATIENTS:

| **Patient Number** | **Age** | **CrMs chart avail. ?**<br><br>**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 or 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 5 yrs from the date of this application)** |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 9 | | | | | | | |
| 10 | | | | | | | |

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**

**EVALUATION OF COLLABORATIVE RELATIONSHIP WITH A FERTILITY*CARE* 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 Fertility*Care* Medical Consultant. Either Option A or Option B must be completed.

**OPTION A**

(to be used only if the Medical Consultant is a Fertility*Care* Practitioner and has no other Practitioner for which he or she provides medical consultation for clients). Please enclose the FertilityCare Practitioner certificate from the completion of your Education Program (must be an Education Program accredited by the Academy) or a letter from your program director documenting completion.

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

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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 Fertility*Care* 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.

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Signature of Applicant Date

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

**OPTION B, PART 2**

**STATEMENT BY FERTILITY*CARE* PRACTITIONER REGARDING COLLABORATIVE RELATIONSHIP WITH APPLICANT FOR CERTIFICATION AS FERTILITY*CARE* MEDICAL CONSULTANT**

NAME OF APPLICANT FOR CERTIFICATION AS MEDICAL CONSULTANT

_____

NAME OF EVALUATING FERTILITY*CARE* PRACTITIONER_____
Telephone Number of Evaluating Fertility*Care* 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 Fertility*Care* 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 Fertility*Care* 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:**


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AAFCP Commission on Certification
FertilityCare Center of Reno, Inc.
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Reno, NV 89502
PHONE 775-827-5111
FAX 775-204-9375
**EMAIL** certificationfcmc@aafcp.net

**ATTACHMENT #3**

**OBSERVATION OF THE WORK OF A FERTILITY*CARE* PRACTITIONER**
(Assessment 6.2.5)

NAME OF APPLICANT_____

This form must be submitted to the Academy as part of the application for initial certification as a Fertility*Care* Medical Consultant. (If the applicant, is also a Fertility*Care* Practitioner, documentation of completion of the Fertility*Care* Practitioner Education Program may be submitted in lieu of this form.) This form provides documentation that you have attended 1 introductory session AND either

3 follow-up sessions and 1 pregnancy evaluation session
OR
5 follow-up sessions

All sessions must have been conducted by a Fertility*Care* Practitioner. If you wish, these sessions may include sessions in which you or your spouse were the clients. Please make sure that you do NOT submit the names or any other identifying information (e.g., telephone number) for any of the clients that attended any of these sessions.

| **DATE** | **Type of Session** | **Follow-up Number for this Client** | **Age of Client** | **CrM Reproductive Category of Client** | **Name of Practitioner** |
|---|---|---|---|---|---|
| | INTRODUCT-ORY | NA | | | |
| | PREGNANCY EVALUATION | NA | | | |
| | FOLLOWUP (1) | | | | |
| | FOLLOWUP (2) | | | | |
| | FOLLOWUP (3) | | | | |
| | FOLLOWUP (4) | | | | |
| | FOLLOWUP (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**

**CONTINUING EDUCATION HOURS IN NAPROTECHNOLOGY AND THE CREIGHTON MODEL FERTILITY*CARE* 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 as a Fertility*Care* Medical Consultant. At least 10 hours of acceptable Continuing Education completed within the last 3 years must be documented for initial certification.

NAME OF APPLICANT_____

| **Continuing Education Option** | **Credit Hours Available** | **Credit Hours Completed** | **Date Completed** |
|---|---|---|---|
| Attending Annual Meeting of the American Academy of Fertility*Care* Professionals<br>Which Meetings? _____ | See annual meeting brochure or program | | |
| Listening to Recordings from Annual Meeting of the American Academy of Fertility*Care* Professionals<br>Which Meeting? _____ | See annual meeting brochure or program | | |
| Studying the current edition of **The Medical and Surgical Practice of NaProTechnology**<br>What is the publication year on the edition?_____ | 30 | | |
| Studying the current edition of Reproductive Anatomy and Physiology for the Fertility*Care* Practitioner<br>What is the publication year on the edition?_____ | 3 | | |
| Studying the current edition of Book 1 for the Fertility*Care* Practitioner<br>What is the publication year on the edition?_____ | 2 | | |
| Studying the current edition of Book 2 for the Fertility*Care* Practitioner<br>What is the publication year on the edition?_____ | 5 | | |
| Attending Annual Meeting of the International Institute of Restorative Reproductive Medicine<br>Which Meetings?_____ | 5 | | |
| Attending other Restorative Reproductive Medicine Conference or Webinars. Please provide details. Subject to the approval of the Certification Subcommittee.<br>_____<br>_____ | 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 #5**

**LETTER OF REFERENCE**

On behalf of _____, who is a candidate applying for certification as a Fertility*Care* 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 in his or her practice of medical NaProTechnology and professional activities.

Please send the letter to:


Gretchen V. Marsh, D.O., CFCMC, CFCP
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PHONE 775-827-5111
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The letter may be sent by email or regular mail.