AMERICAN ACADEMY
OF
FERTILITY*CARE* PROFESSIONALS

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

Updated July 2019

The original application, certificate of medical consultant program completion, and attachments 1, 2A, and 3, and fee payment confirmation should be returned to:

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. When possible, you are encouraged to submit 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 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.

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**

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

Inquiries should be addressed to Dr. Marsh

American Academy of Fertility*Care* Professionals

Application for Renewal of Certification for the Fertility*Care* Medical Consultant

UNLESS OTHERWISE SPECIFIED, ALL REQUESTED INFORMATION APPLIES TO THE CREIGHTON MODEL FERTILITY*CARE* 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 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. 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 Fertility*Care* 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 Fertility*Care* 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 review for most of the cases you submit

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 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 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 FERTILITY*CARE* 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 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. Documentation of completion of the FertilityCare Practitioner Education Program is required.

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.

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.

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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EMAIL certificationfcmc@aafcp.net

ATTACHMENT #3

REQUIRED FORM FOR SUBMISSION OF CONTINUING EDUCATION CREDITS 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 or renewal of certification as a Fertility*Care* 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 Fertility*Care* Professionals (AAFCP) Which meetings?_____	See annual meeting brochure or program		
Listening to Recordings from Annual Meeting of the American Academy of Fertility*Care* Professionals Which Meetings?_____	See annual meeting brochure or program		
Studying the current edition of **The Medical and Surgical Practice of NaProTechnology** What is the publication year on the edition?_____	10		
Studying the current edition of Reproductive Anatomy and Physiology for the Fertility*Care* Practitioner What is the publication year on the edition?_____	3		
Studying the current edition of Book 1 for the Fertility*Care* Practitioner What is the publication year on the edition?_____	2		
Studying the current edition of Book 2 for the Fertility*Care* Practitioner What is the publication year on the edition?_____	5		
Preparing and teaching in an accredited FertilityCare Education Program	15		
Attending Annual Meeting of the International Institute of Restorative Reproductive Medicine Which meetings?_____	5		
Attending other Restorative Reproductive Medicine Conference or Webinars. Please provide details. Subject to the approval of the Certification Subcommittee. _____ _____	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 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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FAX 775-204-9375
EMAIL **certificationfcmc@aafcp.net**

The letter may be sent by email or regular mail.