AMERICAN ACADEMY
OF
FERTILITY*CARE* PROFESSIONALS

APPLICATION FOR
INITIAL CERTIFICATION
FOR THE
FERTILITY*CARE*
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:

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 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 (https://aafcp.net/medical-consultant-certification/).

*The Letter of Reference and Statement of Collaborative Relationship with a Fertility*Care* Practitioner 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: certification@aafcp.net

.

***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 Initial Certification of the Fertility*Care* Medical Consultant after the St. John Paul II Fellowship

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):______________

St. John Paul II FELLOWSHIP (completion date) (Standard 4.0):______________________________

I. Name of Creighton Model Fertility*Care* 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 Parts I, II, III, & IV results of the Final Examination as well as certificates or certifying letters verifying completion of the CrMS Medical Consultant education program and the fellowship program. (Standard 2.2.1)

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 the Director of the Fellowship Program, to be sent directly to the Chairman, Commission on Certification. (Standard 1.2.2)

IV. MEDICAL CONSULTANT ACTIVITIES: (Standard 3.0)

A. Do you attest that you are providing Creighton Model Fertility*Care* services?

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: Evaluation of Collaborative Relationship with Fertility*Care* Practitioner
Attachment #2: Letter of reference for Code of Ethics (described in III-B above)

ATTACHMENT #1

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 submit Fertility*Care* 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 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 Dr. Marsh.**

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.

	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:

Gretchen V. Marsh, D.O., CFCMC
AAFCP Commission on Certification
FertilityCare Center of Reno, Inc.
1281 Terminal Way, Suite 113
Reno, NV 89502
PHONE 775-827-5111
FAX 775-204-9375
EMAIL **certificationfcmc@aafcp.net**

ATTACHMENT #2
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
AAFCP Commission on Certification
FertilityCare Center of Reno, Inc.
1281 Terminal Way, Suite 113
Reno, NV 89502
PHONE 775-827-5111
FAX 775-204-9375
EMAIL **certificationfcmc@aafcp.net**

The letter may be sent by email or regular mail.