

# APPLICATION

## CREIGHTON MODEL FertilityCare™ System

### FERTILITYCARE PRACTITIONER/INSTRUCTOR PROGRAM

Please indicate the program for which you are applying:

Practitioner       Instructor       Auditor       Medical Consultant \*(see pg. 8)

**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 (Print) \_\_\_\_\_  
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.

| NAME OF INSTITUTION            | LOCATION | DATES ATTENDED | DIPLOMA/ DEGREE | DEGREE INITIALS |
|--------------------------------|----------|----------------|-----------------|-----------------|
| High School:                   |          | From – To      |                 |                 |
| Trade or Vocational Schools:   |          | From - To      |                 |                 |
| Certificate                    |          | 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           |
|------------------------------------|------------------------------------|--------------------------|
| a)                                 |                                    |                          |
| Responsibilities:                  |                                    |                          |
| Full time <input type="checkbox"/> | Part Time <input type="checkbox"/> | Reason for leaving _____ |

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| OCCUPATION/TITLE                   | LOCATION                           | DATES EMPLOYED           |
|------------------------------------|------------------------------------|--------------------------|
| b)                                 |                                    |                          |
| Responsibilities:                  |                                    |                          |
| Full time <input type="checkbox"/> | Part Time <input type="checkbox"/> | Reason for leaving _____ |

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| OCCUPATION/TITLE                   | LOCATION                           | DATES EMPLOYED           |
|------------------------------------|------------------------------------|--------------------------|
| c)                                 |                                    |                          |
| Responsibilities:                  |                                    |                          |
| Full time <input type="checkbox"/> | Part Time <input type="checkbox"/> | Reason for leaving _____ |

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| OCCUPATION/TITLE                   | LOCATION                           | DATES EMPLOYED           |
|------------------------------------|------------------------------------|--------------------------|
| d)                                 |                                    |                          |
| Responsibilities:                  |                                    |                          |
| Full time <input type="checkbox"/> | Part Time <input type="checkbox"/> | 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<br>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 | 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?

- |  |   |                                |                                     |
|--|---|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Introductory Lectures     | - | <input type="checkbox"/> Group | <input type="checkbox"/> Individual |
| <input type="checkbox"/> Follow-up Interviews      | - | <input type="checkbox"/> Group | <input type="checkbox"/> Individual |
| <input type="checkbox"/> Phone Advising/Counseling |   |                                |                                     |
| <input type="checkbox"/> Correspondence Counseling |   |                                |                                     |

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

- Client continuing with same teacher
- Attendance at session(s) by Spouse/partner/fiancé
- Conference with other teachers to discuss difficult cases
- 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?

- Self-training
- Informal training
- Semi-formal training
- 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
  - In-service 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: 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
- 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
- Adequate time for course/client work
- Family cooperation with completion of program
- 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 = Unsure      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 Unsatisfied      2 = Unsatisfied      3 = Unsure      4 = Satisfied      5 = Very Satisfied

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

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

1 = Very Unreceptive      2 = Unreceptive      3 = Unsure      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 – 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<sup>TM</sup> Centers of America and FertilityCare<sup>TM</sup> Centers International, have been introduced. These new organizations are designed to unite CREIGHTON MODEL FertilityCare<sup>TM</sup> 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<sup>TM</sup> System teaching materials for client instruction.

It is important for your understanding of this program that you read, sign and date the following:  
 I understand upon completion of the Pope Paul VI Institute CREIGHTON MODEL FertilityCare<sup>TM</sup> Allied Health Practitioner Education Program, in order to purchase CREIGHTON MODEL FertilityCare<sup>TM</sup> 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** \_\_\_\_\_

Indicate if you will be teaching with an existing FertilityCare™ Center or establishing a new center once you complete the program.

I will be teaching with an existing FertilityCare™ Center:  
Center: \_\_\_\_\_

\_\_\_\_\_  
Name of Center

I will be establishing a new FertilityCare™ Center

42. **ESSAY:** Answer the following essay question in approximately 500 words, using a separate sheet of paper:

“Why is teaching the **CREIGHTON MODEL FertilityCare™** System and providing professional FertilityCare services important to me?” (Discuss 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.)

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

44. Have **two letters of reference** sent under separate cover directly to the Program Director, Nancy McGrath. (see below)

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**Your application will be reviewed when all of the following items have been received.**

\_\_\_ 1. Completed **application** and **essay**

\_\_\_ 2. Recent **photograph**

\_\_\_ 3. **Application fee** - \$25.00 (U.S. Funds only) Male check payable to the Dioceses of Chalesston, SC.

**Mail** above items to:

Nancy McGrath, RN, BS, CFCP, CFCE  
603 Rosebud Lane  
Greer, SC 29650

I have read the Program Brochure, a Year in the Life of a Practitioner, and agree to accept these responsibilities should I be accepted into the Program.

**Please initial here:** \_\_\_\_\_

Arrange for **letters of reference** to be mailed directly to the address noted above.

\*\*\*Notification of acceptance/ non-acceptance will be made after a these letters are received and a phone interview conducted.\*\*\*

There will be a **\$100 fee** assessed for all applications received after **March 21, 2021**. It is important to submit the application as early as possible in order to receive the advance information packet in a timely fashion.

**No applications will be accepted after April 7, 2021**

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.

Medical Consultant Program applicants **must** complete a Medical Consultant Program application from Pope Paul VI Institute. Please contact the Education Department for an application: (402) 390-9168 or email at [education@popepaulvi.com](mailto:education@popepaulvi.com).