

APPLICATION

CREIGHTON MODEL Fertility *Care*™ System

Practitioner Education Program – St. Paul

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 Code (Postal) Country

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

_____ City State Zip Code (Postal) Country

5. Telephone Home (____) _____ Work (____) _____

Cell (____) _____ If outside the USA, please indicate country code and city code.

6. Fax (____) _____ 7. Email _____
If outside the USA, please indicate country code and city code.

8. Religion _____ 9. Citizen of _____

10. Ethnic Origin _____ 11. Your primary language: _____

Are you fluent in 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:** Give a complete list of **all** educational institutions attended or are currently attending.

INSTITUTION NAME LOCATION DATES ATTENDED DIPLOMA/DEGREE DEGREE INITIALS

High School:		From – To		
Trade or Vocational Schools:		From - To		
College or University:		From - To		
Graduate or Professional:		From - To		

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

OCCUPATION/TITLE LOCATION DATES EMPLOYED

1)

Responsibilities:

Full time _____ Part Time _____ Reason for leaving _____

OCCUPATION/TITLE LOCATION DATES EMPLOYED

2)

Responsibilities:

Full time _____ Part Time _____ Reason for leaving _____

OCCUPATION/TITLE**LOCATION****DATES EMPLOYED**

3)

Responsibilities:

Full time _____ Part Time _____ Reason for leaving _____

OCCUPATION/TITLE**LOCATION****DATES EMPLOYED**

4)

Responsibilities:

Full time _____ Part Time _____ Reason for Leaving _____

16. If you are a Homemaker, state the number of years: _____ Full-Time ___ or Part-Time ___

17. Have you ever done volunteer work? Yes ___ No ___ Specify: _____

FAMILY PLANNING INVOLVEMENT18. Have you worked in any of the following capacities in a Natural Family Planning (NFP) Program?
(If not, skip to #32.)

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

Indicate whether primarily "paid" or "volunteer"?

19. Where have the NFP Services been provided?

LOCATION	TITLE	SPACE RENTED OR DONATED
Private Home		
Public Building		
Church Premises		

LOCATION	TITLE	SPACE RENTED OR DONATED
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?

- Introductory Lectures Group or Individual
 Follow-up Interviews Group or Individual
 Phone Advising/Counseling
 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.

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 need?

- 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 questions, 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 natural method being taught
- Married
- Married with Children
- Well educated
- Well trained in NFP
- Confident in NFP

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

- 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
- 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)

Currently _____	Length of Use _____
2 nd Most Recent _____	Length of Use _____
3 rd Most Recent _____	Length of Use _____
4 th 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 Unconfident 2 = Unconfident 3 = Unsure 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 = 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

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 _____

Check one:

- I intend to teach for an existing affiliated center: _____ (Name).
- I intend to establish a new affiliated center upon completion of the education program.

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.



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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**

Email items 1 and 2 to: Margaret P. Howard, MAM, CFCE - mphoward.cfce@gmail.com

___ 3. Arrange for **letter of reference** to be emailed to Margaret P. Howard, MAM, CFCE - mphoward.cfce@gmail.com.

___ 4. **Application fee** - \$50.00 via credit card or PayPal (mphoward.cfce@gmail.com)
(nonrefundable)

To pay by credit card, please complete:

Type of card:	
Card Number:	
Expiration Date:	
Security Number:	
Amount:	

Apply early!
Advance preparation is required.

Application deadline: July 1, 2020
Applications received after July 1, 2020 will be charged \$200 late Fee.

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.

FertilityCare Services Limited Education Programs