

FertilityCare Center of Kansas City APPLICATION

CREIGHTON MODEL FertilityCare System FERTILITYCARE PRACTITIONER/INSTRUCTOR PROGRAM

Please indicate the program for which you are applying:

Practitioner

Instructor

Auditor (Practitioner)

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 _____ Work _____
Home (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		
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 _____

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

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

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

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: _____

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 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.

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

<input type="checkbox"/>	Female
<input type="checkbox"/>	Female in reproductive years
<input type="checkbox"/>	A Natural Family Planning user-acceptor
<input type="checkbox"/>	A user-acceptor of the NFP method being taught
<input type="checkbox"/>	Married
<input type="checkbox"/>	Married with children
<input type="checkbox"/>	Well educated
<input type="checkbox"/>	Well trained in NFP
<input type="checkbox"/>	Confident in NFP
<input type="checkbox"/>	Confident in NFP method being taught
<input type="checkbox"/>	Willing to refer for psycho-social counseling (e.g. marriage, family)
<input type="checkbox"/>	Willing to refer for medical problems
<input type="checkbox"/>	Willing to refer for artificial contraceptive methods
<input type="checkbox"/>	Willing to refer for induced abortion
<input type="checkbox"/>	Similar social class background to that of client
<input type="checkbox"/>	Similar age to that of client
<input type="checkbox"/>	Socially acquainted with clients (e.g. same church, same community)
<input type="checkbox"/>	A medical orientation
<input type="checkbox"/>	A family orientation
<input type="checkbox"/>	Stable in particular vocation
<input type="checkbox"/>	Open to criticism, failure
<input type="checkbox"/>	Non-judgmental/supportive
<input type="checkbox"/>	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 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
- 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 you 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 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, sign and date the following:
 I understand upon completion of the Pope Paul VI Institute CREIGHTON MODEL FertilityCare™ 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

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:
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 **one letter of reference** sent under separate cover directly to the Program Director.

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** - \$50.00 (U.S. Funds only)

Mail to: Brooke Hendren, CFCE
Teacher Education Program Director
FertilityCare Center of Kansas City
PO Box 343
Blue Springs, MO 64013

- ___4. Arrange for **letter of reference**, addressed to Phyllis A White, CFCE, Program Director.

Mail to: Brooke Hendren, CFCE
Teacher Education Program Director
FertilityCare Center of Kansas City
PO Box 343
Blue Springs, MO 64013

There will be an additional **\$100 late fee** assessed for applications received **after Oct 1, 2022**. It is important to submit your application by this date in order to receive the advance information packet in a timely fashion.

No applications will be accepted after Oct 1, 2022

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.