APPLICATION

St. Gianna Center for Women's Health and FertilityCare™

CREIGHTON MODEL Fertility*Care*™ System

PRACTITIONER EDUCATION PROGRAM

Please indicate the program for which you are applying:

❒ **Practitioner** ❒ **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 Cell** (____)________________________ **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**____

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
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 ______ Part Time______ Reason for leaving____

____

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

b)

Responsibilities:

Full time ______ Part Time______ Reason for leaving____

____

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

c)

Responsibilities:

Full time ______ Part Time______ Reason for leaving____

____

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

d)

Responsibilities:

Full time ______ Part Time______ 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 (See #17)	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?

- ☐ a. Introductory Lectures
- ☐ b. Follow-up Interviews
- ☐ c. Phone Advising/Counseling
- ☐ d. Correspondence Counseling

If you marked a and/or b, were these individual or group? __________

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

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

- ☐ a. Self-training
- ☐ b. Informal training
- ☐ c. Semi-formal training
- ☐ d. 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
- ☐ Inservice 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: Please 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

1 = Absolutely Not Important **2** = Not Important **3** = Important **4** = Very Important

- ☐ 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. If used for purposes of monitoring fertility only, please indicate as such.)

Current____ Length of Use_____________________

2nd Most Recent___________________________________ Length of Use_____________________

3rd Most Recent ___________________________________ Length of Use_____________________

4th 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 Unsatisfied **2** = Unsatisfied **3** = Unsure **4** = Satisfied **5** = Very Satisfied

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 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, Fertility***Care***™ Centers **of America** and Fertility***Care***™ Centers **International**, have been introduced. These new organizations are designed to unite **CREIGHTON MODEL** Fertility ***Care***™ Centers nationwide and worldwide. Please note: any Practitioner or Center must become an affiliate or participate in an affiliated program to order **CREIGHTON MODEL** Fertility***Care***™ 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** Fertility***Care***™ System Allied Health Practitioner Education Program, in order to be purchase **CREIGHTON MODEL** Fertility***Care***™ System teaching materials, I will need to become an affiliate or participate in an affiliated program with Fertility***Care***™ Centers **of America** or Fertility***Care***™ Centers **International.**

    Signature____**Date**__________________________

42. **ESSAY**: Please answer the following question in approximately 500 words on a separate sheet of paper.

    "Why is teaching the **CREIGHTON MODEL** Fertility***Care***™ System and providing professional FertilityCare services important to me?"
    (Include in your answer some commentary regarding your motivation for seeking to become a Fertility***Care***™ *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.

Your application will be reviewed once all of the following items have been received:

___1. Completed Application

___2. Letter of Reference to Program Director

___3. Recent Snapshot

___4. Application Fee - $50.00 (U.S. Funds only)

___5. Mail the above items to:

St. Gianna's Center For Women's Health and FertilityCare Education Program
PO Box 12691
St Petersburg, Florida 33733-2691
Attention: Diane M. Hale, RN, CFCE
Education Program Director

___6. Or email Items 1-3 to: Diane.Hale@StGiannaCenter.com
Please make a payment of $50 for your application fee at https://www.stgiannacenter.com/fees/ and select PayPal or Credit Card or Contact us at info@stgiannacenter.com and we'll issue you an invoice which will allow you to make a payment online.

It is important to submit your application well before the dates of the education program in order to allow for processing and to receive the advance information packet in a timely fashion.

Application information will be used for evaluating applicant acceptance, **not** for treatment purposes. The application will be kept as part as the Education Program's academic or continuing education's records.