



The Fetal Medicine Foundation

Founded by Prof. Kypros Nicolaides in 1995

ANNUAL RE-ACCREDITATION FORM

NOTE: This form is intended for use ONLY by those who are unable to upload images and/or data directly to the Fetal Medicine Foundation website, www.fetalmedicine.org. Information and instructions for sending images electronically can be found at www.fetalmedicineusa.com.

Please check (✓) each item that applies and fill in requested information completely!

- I have completed the online 11 – 13 weeks scan course via the Fetal Medicine Foundation website.
- I have verified that my contact information on my “own page” is up-to-date and accurate.

Your name: _____ FMF ID #: _____ Center ID#: _____

- MD
- RDMS ARDMS#: _____
- Other: _____

Best contact # before 5:00pm: work home cell _____

Please send correspondence to: work home

1.) Submit 3 images for each accreditation held. Renewal (including extra markers) is required annually. ALL of the additional markers’ renewal date defaults to the NT expiry date regardless of the date of initial accreditation.

- NT NB TF DV Uterine Doppler (PET)

Please note, the Pulsatility Index MUST be measured on the DV and Uterine Doppler images.

For NB and TF submission, please specify if you are including a normal or abnormal image.

On EACH image: block the patient name, include the date and time of exam on the image.

Images that are older than the last audit and older than 12 months will NOT be accepted.

2.) Submit data (data is the list of CRLs and NT measurements you have performed in the past year/audit period) check what applies:

- I have performed less than 30 NT scans in the past year, therefore, my re-accreditation will be based on images alone.

I use the First Trimester Screening software and will upload my data directly.

I send my NT measurements to a lab for risk calculation.

Name of lab(s): _____

I give permission to the Fetal Medicine Foundation USA to contact the lab(s) I use in order to retrieve and analyze my data for re-accreditation purposes. I understand that no identifiable patient information will be included in this file in compliance with HIPPA.

Signed: _____ Date: _____

Please note NEW MAILING ADDRESS FOR RE-ACCREDITATION MATERIALS:

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