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 #: _____ **Please note the following change:**

Annual fee for reaccreditation:

$30 for Sonographers, Residents, and Fellows

The link for sonographers to pay the reaccreditation fee is https://www.paypal.com/ncp/payment/DCP6YSHNG47CS.

$100 for Attending Physicians

The link for MDs/DOs to pay the reaccreditation fee is https://www.paypal.com/ncp/payment/AMLNWL7FQF74J OR go to Fetalmedicineusa.com and click on the "Pay Re-accreditation Fee" located on the right side of the home page.

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

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:
Cathy Downing RT, RDMS, RVT
USA Audit
Fetal Medicine Foundation USA
4A Flanagan Drive
Shrewsbury, MA 01545
Email:USAaudit@fetalmedicine.com
Phone: 937-416-4248