

Calloway County Health Department

APPLICATION FOR WIC BREASTFEEDING PEER COUNSELOR

Breastfeeding Peer Counselors provide basic information about breastfeeding to WIC mothers during their pregnancy, and after the baby is born. They encourage mothers to breastfeed, and help mothers find help if problems occur.

The Breastfeeding Peer Counselor must meet all of the following listed qualifications:

- Be a contemporary/cohort/equal to the woman to whom she will be providing information and support. This includes speaking the ability to speak Spanish, if needed;
- Has been or currently is a WIC participant;
- Has breastfed at least one baby for six (6) months or longer and is an advocate for breastfeeding
- Has the ability to work independently at home.
- Has reliable transportation;
- Be readily accessible by phone;
- Has basic computer skills; and
- Has the ability to communicate effectively with peers, supervisors, and other health department staff.

Please provide the following information:

1. Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail address (if applicable): _____

What languages, other than English, do you speak? _____

2. Have you participated in the WIC Program? Yes No

If yes, When? From _____ To _____

If yes, at which agency/county did you receive WIC services? _____

3. Do you have basic computer skills including email Yes No

Word Processing (such as Microsoft Word) Yes No

4. Circle the highest grade you have completed:

Grade School: 1 2 3 4 5 6 7 8

High School: 9 10 11 12

College: 1 2 3 4 Other

5.

Ages of your children	How long did you breastfeed this child?

6. **Employment History**

List previous job or volunteer experience beginning with current or most recent.

a. Employer Name:

Job Duties:

Dates of Employment (Month/Year): From: _____ To: _____

Reason for Leaving:

b. Employer Name:

Job Duties:

Dates of Employment (Month/Year): From: _____ To: _____

Reason for Leaving:

c. Employer Name:

Job Duties:

Dates of Employment (Month/Year): From: _____ To: _____

Reason for Leaving:

7. **References:** List contact information for three people to be used as references.

Name: _____

Phone Number: _____

E-mail address: _____

Name: _____

Phone Number: _____

E-mail address: _____

Name: _____

Phone Number: _____

E-mail address: _____

As a condition of employment, I understand a background check is required and I give consent for it to be completed.

I understand the agency where I participated in the WIC Program will be contacted and my status as a WIC participant will be verified.

Signature: _____ **Date:** _____