

WIC Peer Counselor Program Guidelines

Application for Peer Counselor Position

Your Health District information

Address

City, GA ZIP

Phone

FAX

USING *Loving Support*[®] TO MANAGE
PEER COUNSELING
P R O G R A M S

Application: 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. Qualifications:

- Have breastfed **at least one baby for 6 months or more** (do not have to be currently breastfeeding)
- Previous or current WIC participant
- Are enthusiastic about breastfeeding, and want to help other mothers enjoy a positive experience
- Can work about 20 hours a week
- Have a telephone, and are willing to make phone calls from home
- Have reliable child care and transportation

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

E-mail address (if applicable): _____

What languages do you speak? _____

Social security number or WIC ID Number: _____

Circle 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 _____

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Tell us about your children.

Name	Age	How long did you breastfeed this child?

Why do you want to be a Peer Counselor for the WIC Program?

Tell us why you think you will be a good peer counselor. Include any job experience or volunteer work you have done that will help you as a peer counselor.

Check off all of the following that you are able to do:

_____ Attend the training program (three classes of about 6 hours each; may bring your nursing baby with you. These are spaced several weeks apart.)

_____ Talk to pregnant and breastfeeding moms from your telephone at home.

_____ Talk to WIC mothers in the clinic.

_____ Make home visits with new mothers.

_____ Visit new mothers in the hospital.

_____ Help with a breastfeeding class or a support group.

Do you have reliable transportation? _____ Yes _____ No

Do you have childcare available for young children? _____ Yes _____ No

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Reference: Include the name of a healthcare provider such as a WIC nutritionist, nurse, physician, or breastfeeding counselor who knows about your breastfeeding experience.

Name: _____

Address: _____

Phone Number: () _____

Your Signature: _____ **Date:** _____

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