Peer Counselor Participant Survey

"This is _____ from (Health Dept., Clinic, or what term you use to best describe your local agency to participants). I work with the Breastfeeding Peer Counselors there. We are calling you in an effort to assess our Peer Counseling Program. Is this a good time for a short survey regarding your participation in our Peer Counseling Program?"

	Peer Counselor Name: _____	Has your PC called and/or contacted you regularly?	How has her contacts been helpful to you?	Would you use the PC Program in the future?	In your opinion, how can we improve our program to better support breastfeeding moms?
1)	**Mother's Name:** _____ **WIC ID #:** _____ **Date of Survey:** _____	❑ Yes ❑ No		❑ Yes ❑ No ❑ N/A	
2)	**Mother's Name:** _____ **WIC ID #:** _____ **Date of Survey:** _____	❑ Yes ❑ No		❑ Yes ❑ No ❑ N/A	
3)	**Mother's Name:** _____ **WIC ID #:** _____ **Date of Survey:** _____	❑ Yes ❑ No		❑ Yes ❑ No ❑ N/A	
4)	**Mother's Name:** _____ **WIC ID #:** _____ **Date of Survey:** _____	❑ Yes ❑ No		❑ Yes ❑ No ❑ N/A	

Surveyor's Signature & Title: _____ **Date:** _____

*The "Peer Counselor Participant Survey" is intended to allow Peer Counselor Managers to evaluate services provided by Peer Counselors.

Number of Hours Worked by Peer Counselor:	Required Number of "Peer Counselor Participant Surveys" **Monthly for each PC**
0-20 Hours Week	2
More than 20 Hours a Week	4