OMB Control#: 0584-0548
Expiration Date: xx/xx/20xx

Appendix C1: Demonstration Period Progress Form

OMB Control#: 0584-0548
Expiration Date: xx/xx/20xx

Demonstration Period Progress Form

OMB Clearance Number: 0584-0548 Expiration Date: xx/xx/20xx
According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0584-0548. The time required to complete this information collection is estimated to average one hour per response. If you have any comments concerning the accuracy of time estimates or suggestions for improving this form, please contact: U. S. Department of Agriculture, Food and Nutrition Service, Office of Research & Analysis, Room 1014, Alexandria, VA 22302.

This biweekly progress report covers contacts made xx/xx/2011 through xx/xx/2011.

Click here to adjust these dates: ❍

RECORD #1	**Enter mother's first name:**	
Was contact made while mother was IN HOSPITAL to deliver her infant?		❑Yes ❑No
Name of Peer Counselor who made contact		
Name of hospital where mother delivered		
Mode of contact	❑ Telephone ❑ In-person ❑ Other, specify:	

If special cirumstances limited peer counselor's ability to provide breastfeeeding peer counseling while mother was in the hospital, please indicate below: (***check all that apply***)

- ❑ Unable to contact mother in hospital, unknown reason
- ❑ Mother or infant had a health problem
- ❑ Family member or health care provider objection
- ❑ Other **known** circumstance (information withheld)

Was IN-PERSON contact with mother made after she gave birth?	❑Yes ❑No
Name of Peer Counselor who made contact	
Infant was how many days old?	Days
Location (*check one*):	❑ WIC clinic ❑ Mother's home ❑ Hospital ❑ Other, specify:
Duration of in-person meeting	____ Hours, ___Minutes
Language(s) used by peer counselor	
Language(s) used by mother	

Go to Next Record

This biweekly progress report covers contacts made xx/xx/2011 through xx/xx/2011.	
Click here to adjust these dates: ❍	
RECORD #1	Enter mother's first name:
Was contact made while mother was IN HOSPITAL to deliver her infant?	❑Yes ❑No
Name of Peer Counselor who made contact	
Name of hospital where mother delivered	
Mode of contact	❑ Telephone ❑ In-person ❑ Other, specify:
If special cirumstances limited peer counselor's ability to provide breastfeeeding peer counseling while mother was in the hospital, please indicate below: (*check all that apply*) ❑ Unable to contact mother in hospital, unknown reason ❑ Mother or infant had a health problem ❑ Family member or health care provider objection ❑ Other **known** circumstance (information withheld)	
Was IN-PERSON contact with mother made after she gave birth?	❑Yes ❑No
Name of Peer Counselor who made contact	
Infant was how many days old?	Days
Location (*check one*):	❑ WIC clinic ❑ Mother's home ❑ Hospital ❑ Other, specify:
Duration of in-person meeting	____ Hours, ___Minutes
Language(s) used by peer counselor	
Language(s) used by mother	

Go to Next Record

[Note to OMB: Records (#1, #2, ..., *n*) continue with one record for each WIC participant with whom contact was made during the two-week period covered by each Demonstration Period Progress Form, assuming approximately 20 records entered per Demonstration Period Progress Form]