

Appendix C1: Demonstration Period Progress Form

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.	
<i>Click here to adjust these dates:</i> <input type="radio"/>	
RECORD #1	Enter mother's first name:
Was contact made while mother was IN HOSPITAL to deliver her infant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Peer Counselor who made contact	
Name of hospital where mother delivered	
Mode of contact	<input type="checkbox"/> Telephone <input type="checkbox"/> In-person <input type="checkbox"/> Other, specify:
If special circumstances limited peer counselor's ability to provide breastfeeding peer counseling while mother was in the hospital, please indicate below: <i>(check all that apply)</i>	
<input type="checkbox"/> Unable to contact mother in hospital, unknown reason <input type="checkbox"/> Mother or infant had a health problem <input type="checkbox"/> Family member or health care provider objection <input type="checkbox"/> Other known circumstance (information withheld)	
Was IN-PERSON contact with mother made after she gave birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Peer Counselor who made contact	
Infant was how many days old?	Days
Location <i>(check one)</i> :	<input type="checkbox"/> WIC clinic <input type="checkbox"/> Mother's home <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify:
Duration of in-person meeting	___ Hours, ___ Minutes
Language(s) used by peer counselor	
Language(s) used by mother	

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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Peer Counselor who made contact	
Name of hospital where mother delivered	
Mode of contact	<input type="checkbox"/> Telephone <input type="checkbox"/> In-person <input type="checkbox"/> Other, specify:
If special circumstances limited peer counselor's ability to provide breastfeeding peer counseling while mother was in the hospital, please indicate below: (check all that apply)	
<input type="checkbox"/> Unable to contact mother in hospital, unknown reason	
<input type="checkbox"/> Mother or infant had a health problem	
<input type="checkbox"/> Family member or health care provider objection	
<input type="checkbox"/> Other known circumstance (information withheld)	
Was IN-PERSON contact with mother made after she gave birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Peer Counselor who made contact	
Infant was how many days old?	Days
Location (check one):	<input type="checkbox"/> WIC clinic <input type="checkbox"/> Mother's home <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify:
Duration of in-person meeting	___ Hours, ___ Minutes
Language(s) used by peer counselor	
Language(s) used by mother	

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[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]