COMPONENT 2: Online Enrollment Form

Please complete all sections prior to submission. You also have the ability to save and come back to your survey at a later time. If you have any questions, please email Enrollment@EMPowerBreastfeeding.org.

Download a copy of the survey before you begin:
EMPower_Training

Section A: Hospital Name and Contact Information

Hospital Name, Address, City, State, Zip Code

Hospital Name: ____

Street Address : ____

Apt/Suite/Office: ____

City : ____

State: ____

Zip Code: ____

Name, Title, and Contact Information of Individual Submitting the Enrollment Materials

First Name: ____

Last Name: ____

Title: ____

Work Phone Number: ____

Work Email Address: ____

Alternate Contact Information

First Name: ____

Last Name: ____

Title: ____

Work Phone Number: ____

Work Email Address: ____

Please upload your signed copy of the Component 1 Form.*

____

SECTION B: Hospital Patient Population Information

2b-2. Number of live births annually at your hospital:

____

2b-2. Distribution of Births at your hospital by race and ethnicity

_________% Hispanic

_________% Non-Hispanic White

_________% Non-Hispanic Black

_________% Non-Hispanic American Indian/Alaska Native

_________% Asian

_________% Two or more races

_________% Other

_________% Not Reported

2b-3. Distribution of Births at your hospital by insurance or payer status (*If not available, please estimate to the best of your ability*)

_________% Private Insurance

_________% Medicaid

_________% CHIP

_________% Self Pay

_________% Unknown

2b-4. Number of staff working on the maternity care unit

Number of nursing staff that work in Maternity Care
: ____

Number of providers with privileges in Maternity Care
: ____

2b-5. Please estimate what percentage of the current maternity care staff have completed 5 hours of competency training in alignment with the Baby Friendly Hospital Initiative Guidelines and Criteria:

____

2b-6. Please estimate what percentage of the current providers have completed 5 hours of competency training in alignment with the Baby Friendly Hospital Initiative Guidelines and Criteria:

____

2b-7. Co-Administration of Facilities.

Is your hospital part of a hospital or healthcare system?

( ) Yes

( ) No

( ) Don't Know

If Yes, please list the name of the hospital or healthcare system:

____

Is another hospital within your system applying to this initiative?

( ) Yes

( ) No

( ) Don't Know

If Yes, please list the name and location of other hospitals within your system that may be applying to be part of this initiative:

Name of Hospital #1: ____
: ____
Location of Hospital #1: _______________________________________
: ____
Name of Hospital #2: ____
: ____
Location of Hospital #2: _______________________________________
: ____
Name of Hospital #3 ____
: ____
Location of Hospital #3: _______________________________________
: ____
Name of Hospital #4 ____
: ____
Location of Hospital #4: _______________________________________
: ____

SECTION C: Hospital Involvement and Leadership Information

2c-1. What is your hospital's current Baby-Friendly status? (Note: This is for informational purposes only. Hospitals are not required to pursue Baby-Friendly designation to be eligible or participate in EMPower Breastfeeding: Training).

( ) Not planning to pursue Baby-Friendly designation

( ) Not yet in the 4-D pathway, but planning to pursue

( ) Discovery (D1)

( ) Development (D2)

( ) Dissemination (D3)

( ) Designation (D4)

( ) Already Designated

2c-2. Has your hospital applied for and/or has your hospital agreed to participate in another project related to implementing the *Ten Steps to Successful Breastfeeding*?

( ) Yes

( ) No

( ) Don't Know

	Yes	**No**	**Don't Know/unsure**
Applied	( )	( )	( )
Agreed to Participate	( )	( )	( )

If yes, please name the project and the date you were accepted or started the project. (Please note 100 word maximum.)

____

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____

____

2c-3. Briefly describe why your facility, including your hospital leadership, is interested in participating in EMPower Breastfeeding: Training. (Please note 300 word maximum.)

____

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____

____

2c-4. Please provide a description of hospital senior leadership who will be involved in the initiative, including their roles. (Please note 250 word maximum.)

____

____

____

____

2c-5. Does your hospital have one or more of the following committees currently active?

[ ] Multidisciplinary Committee

[ ] Infant Feeding Committee

[ ] Other, Specify:

: ____