NATIONAL BREASTFEEDING COMMITTEE MEMBERSHIP APPLICATION FORM

Protecting, Promoting, and Supporting Breastfeeding in Bermuda

APPLICANT INFORMATION

Full Name: ____

Date of Birth: ____

Address: ____

Phone Number: ____

Email Address: ____

PROFESSIONAL INFORMATION

Current Occupation: _______________________________________

Employer/Organization: ____________________________________

Relevant Qualifications/Certifications: _________________________

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Are you currently affiliated with any of the following organizations? (Check all that apply)

☐ Department of Health Services

☐ King Edward Memorial Hospital

☐ Private Pediatrician Office

☐ Le Leche League

☐ Community Organization

Are you an IBCLC (International Board-Certified Lactation Consultant)?

☐ Yes

☐ No

Please list any other relevant professional affiliations:

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COMMITTEE PARTICIPATION

Why do you want to join the National Breastfeeding Committee?

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What skills or experiences will you bring to the committee to help achieve its goals?

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Are you able to commit to attending monthly meetings and participating in at least one committee event per year?

☐ Yes

☐ No

Do you agree to uphold the committee's values and respect the choices of breastfeeding families?

☐ Yes

☐ No

SIGNATURE

I certify that the information provided in this application is true and complete to the best of my knowledge.

Applicant Signature: ________________________________

Date: ________________________________

SUBMISSION INSTRUCTIONS:

Please submit the completed application to healthvisitor@gov.bm