Authorization, Contact Information, Team Members Form for the LIFE program

Authorization

☐ I (or my designee) have reviewed the information about the Lactation and Infant Feeding-Friendly Environment (LIFE) Hospital program and authorize my facility to submit documentation to be recognized as a Lactation and Infant-Feeding Friendly Hospital.

I acknowledge and agree:

This recognition will be listed on the Washington State Department of Health's website and for the Washington State Department of Health to promote Name of Hospital designation level in other ways, including social media.

The Washington State Department of Health will store our application and submitted data for the next seven years, as part of the Public Records Disclosure Act of RCW 42.56. In the event that our hospital's information is requested per Public Disclosure Request, Name of Hospital will be notified per RCW 42.56.540 in which we have the right to challenge disclosure.

The Lactation and Infant Feeding-Friendly Environment (LIFE) Hospital recognition is valid for five years, and our hospital will need to reapply to the program to maintain recognition as a LIFE Facility.

Upon application the LIFE program will contact our facility for further information, use data reported to the Center for Disease Control and Joint Commission, and may suggest changes in our hospital's policies so that our facility can be recognized as a LIFE Hospital.

LIFE designated facilities are expected to have a trauma-informed, patient centered approach to supporting lactation. The LIFE program reserves the right to review policies, procedures, data, and education materials in good faith at any time during the five-year designation period and change our LIFE designation status based on review and subsequent follow up.

I, Your Name, confirm that the data and information in this application is accurate, to the best of my knowledge.

Hospital Name: Click here to enter text

Name of Director for Labor & Delivery: Click here to enter text

Director's Signature: Click here to enter text
The signature may be handwritten or electronic. The format for electronic signatures is /s/Name. For example: /s/Divine Milstead.

Date: Click here to enter text

Facility Contact Information

We may need some additional information from you. Let us know who is coordinating the application for recognition.

Name: Click here to enter text

Title: Click here to enter text

Facility Address: Click here to enter text

Phone: Click here to enter text

Email: Click here to enter text

Application Team Members

We strongly encourage you to put together a team of people to help with this application and process. This team should include the manager or director of Labor and Delivery. To help us understand who is involved in this work, please let us know the types of positions that make up your team. Check all that apply.

- ☐ Family Medicine Provider
- ☐ Labor & Delivery Nurse
- ☐ Lactation Consultant (IBCLC)
- ☐ Maternity Center Administrator or Manager
- ☐ Mother-Baby Care Nurse
- ☐ Night Maternity Nurse
- ☐ Nurse from Newborn Care
- ☐ Obstetrical Provider
- ☐ Pediatric Provider
- ☐ Quality Improvement Coordinator
- ☐ Other relevant staff (please specify)

  Click or tap here to enter text.

Are community members who specialize in lactation support, local advocacy organizations or local health jurisdictions supporting your work?

☐ Yes ☐ No

If you are answering no, would you like additional support or connecting to local organizations?

☐ Yes ☐ No