

Anchorage
Health
Department

HHID:		
	filled out by WIC Staff	

BFPC Enrollment Form

Baby's name (if applicable): Address: Phone: Email: Due Date or Baby's DOB: Sex of baby: I am interested in receiving breastfeeding information. I am currently breastfeeding. I would like some follow-up support with breastfeeding. Explanation: Other: Other: Other: Detection of Anchorage Breastfeeding Peer Counseling (BFPC) program. I understand that the Municipality of Anchorage Breastfeeding information and will not share with the Breastfeeding seeling program any information about me, outside the limits of information needed for BFPC services by release the Municipality, its officers and employees from any liability relating to any and all munications which include telephone, email, mobile text messaging and social media outlets as a reprollment. I understand that participation in the program is strictly voluntary and I freely chose to cipate or end my enrollment at any time and that neither choice will affect my WIC benefits.	Name:	
Phone:	Baby's name (if applicable):	-
Email:	Address:	
Due Date or Baby's DOB: Sex of baby:	Phone: Age:	
Sex of baby: Male Female	Email:	
I am interested in receiving breastfeeding information. I am currently breastfeeding. I would like some follow-up support with breastfeeding. Explanation:	Due Date or Baby's DOB:	·
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