EPIC Breastfeeding Education Trainer Information Sheet

Personal Information:

Name: _____ Credentials: _____

Home Address: _____

City: _____ State: ____ Zip Code: _____County: _____

Home Phone: _____ Home Fax: _____ Cell Phone: _____

E-mail: _____

Business Information:

Specialty: ☐PED ☐OB ☐FP ☐Other: _____

Practice Name: _____

Business Address: _____

City: _____ State: ____ Zip Code: _____County: _____

Business Phone: _____ Ext: _____ Business Fax: _____

Which phone number is best to contact you? ☐Cell ☐Home ☐Business

I am willing to travel within the following mile radius: ☐ <30 ☐ 30-60 ☐ 60-90 ☐ 90+

The best days and time for me to do programs are:

___Monday	☐Not Available	☐Anytime	☐Morning	☐Lunchtime	☐Afternoon	☐Evening
___Tuesday	☐Not Available	☐Anytime	☐Morning	☐Lunchtime	☐Afternoon	☐Evening
___Wednesday	☐Not Available	☐Anytime	☐Morning	☐Lunchtime	☐Afternoon	☐Evening
___Thursday	☐Not Available	☐Anytime	☐Morning	☐Lunchtime	☐Afternoon	☐Evening
___Friday	☐Not Available	☐Anytime	☐Morning	☐Lunchtime	☐Afternoon	☐Evening
___Saturday	☐Not Available	☐Anytime	☐Morning	☐Lunchtime	☐Afternoon	☐Evening
___Sunday	☐Not Available	☐Anytime	☐Morning	☐Lunchtime	☐Afternoon	☐Evening

(The majority of programs will be conducted during the lunch hour.)

CHECKLIST FOR RETURN ITEMS

1) **Trainer Information Sheet**
2) **CME Disclosure Declaration**
3) **GNA Biographical Data Form**
4) **IBCLE Speaker Disclosure Form**
5) **Curriculum Vita/Resume or IBCLE Curriculum Vita Form**
6) **W-9 Form**
7) **Trainer Policy Statement**

Please return all information to:

EPIC Breastfeeding Program
Attn: Arlene Toole BS, IBCLC, RLC
1330 West Peachtree Street, NW, Suite 500
Atlanta, GA 30309-2904
Fax: 404-249-9503
E-mail: atoole@gaaap.org