

Weekly Activity Report

Breastfeeding Peer Counseling Program



Week Ending Date: _____

Clinic/Local Agency: _____

Bay Area WIC Breastfeeding Peer Counseling Program

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Name: _____

Total hours: _____

Date	Name of Contact	Telephone Counsel	Home Visit	Clinic Visit	Hospital Visit	Other Contact	Training/Inservice	Peer Counsel. Meet.	Consultations	Clerical/Admin.	Prenatal Total	Postpartum-bf total	Postpart-Non bf total	Total Num. of Hours	Remarks
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Totals		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	Total page hours in red box