APPLICATION FOR BREASTFEEDING RESOURCE DIRECTORY
INDIVIDUAL PROVIDER OF LACTATION SERVICES LISTING

In order to list your name in the provider section of the directory, you must be a Certified Lactation Professional, or a Licensed Health Practitioner or a La Leche League leader. **Please complete the application below and send with a check (or credit card information) made out to the Breastfeeding Task Force of Greater Los Angeles for $100.00 ($200 if hyperlink to web address is desired) and mail with application to:**

Louise Arce Tellalian
1911 San Ysidro Drive
Beverly Hills, CA 90210-1520
310-274-2272; Fax 310-859-7077

APPLICATIONS MUST BE RECEIVED NO LATER THAN FEBRUARY 1, 2010 FOR INCLUSION IN THE 2010 DIRECTORY. FILL OUT INDIVIDUAL LISTING FORM IN ADDITION.

Contact Information. **(Please block print or type) This information is for office use only and will not be published.**

____
Name

____
Mailing Address

____
City State Zip code + 4

____
Home Phone Business Phone

____
Fax E-mail address

Payment by Check ________________ **Credit Card:**________________

Visa ______ Mastercard ______ Card Number ________________cvv2 ________ Exp.date________

____
Name as it appears on credit card Billing address if different from above

Professional License/Registration: M.D. ______ R.N. _____ L.V.N. _____ R.D. ______ P.T.R. ______ O.T.R. ______

Other ____

Professional License/ Registration Number ________________ Expiration Date ________________

Lactation Certification: List type of certification(s) as written on your certificate, e.g. "certified lactation educator" , certifying agency, date certificate was issued, and expiration date if applicable.

____
Type of certification Certification Agency

____
Date issued Expiration date if applicable

I VERIFY THAT ALL INFORMATION ON MY APPLICATION IS TRUE AND ACCURATE

____
Signature **Date**

PLEASE FILL OUT INDIVIDUAL LISTING FORM THAT FOLLOWS AS WELL.

HOW WOULD YOU LIKE TO BE LISTED IN THE DIRECTORY?

The directory will list you in your primary service area **only** and list after your name additional areas served. Please restrict the credentials after your name, and the other services listed, to those relevant to breastfeeding. **The number of text lines per listing is limited to six (6), 80 characters/spaces per line . If you were listed last year, attach your listing and just add changes below.**

Example: Jane R. Doe, RN, BSN, CLC 818-555-1212
000 Main Street, Los Angeles 90000
Also serves South Bay
Breastfeeding classes, prenatal; consults in office, client's home;
breast pump rentals & related sales; free pump delivery;
available weekends; Spanish spoken

____
Name and credentials (individual and / or business name)

____
Street Address (optional).

____
City State Zip code + 4

____
Primary service area Secondary service area

Contact Phone ( ) ____________________ **Alternate #** ( )____________________

Services offered: (check all that apply below) Do you wish listing to be exactly like last year? ____________________

Breastfeeding Classes: Group Prenatal _______ Group Post partum _______ Private Instruction _______ Other____________

Consults: In client's home _________ Your office _________ Hospital inpatient ________ In pediatric office____________

WIC center ____________ Hospital clinic ____________ Other ______________________________

Breast pump: Purchase __________ Rentals _________ Related sales _________ Pump delivery ________________

Special breastfeeding services: (teens, developmentally disabled, hearing impaired, support groups)

____

Do you accept credit cards? _______ Include web address if a live hyperlink is desired ($100 extra) ________________

Do you provide **free** ____________________ or **MediCal reimbursable** ________________ services?

In what languages do you provide services? ______________________________

Are services provided on weekends? ______________ evenings? ____________________

Review your listing to make sure it meets the space limitations stated above.

DID YOU FILL OUT THE INDIVIDUAL APPLICATION FORM? FILL OUT AND MAIL QUESTIONNAIRE WITH APPLICATION

PLEASE SUBMIT THE FOLLOWING QUESTIONNAIRE TO:

Louise Arce Tellalian
1911 San Ysidro Drive
Beverly Hills, CA 90210-1520
310-274-2272; Fax 310-859-7077

PLEASE BLOCK PRINT OR TYPE

1. Your name ____

2. Do you wish to be kept on Directory **application** mailing list? Yes ____________ No _______________

3. Are you listing yourself as a lactation provider for 2010? Yes_____________ No _______________

Reason ____

4. Do you know of any other lactation professional that would be interested in receiving this mailing? If so, please provide their:

____

Name | Mailing address

____

City | State | Zip code + 4

____

Phone number | E-mail Address