**Baby Friendly Hospital Initiative**

**Application form of commitment:**

*The candidate hospital must ensure that it prepares the following documents and fulfils the following requirements before filling out and signing this form:*

|  |  |
| --- | --- |
| ✓ | **Requirements/ Documents** |
|  | **BFHI committee** |
|  | **Breastfeeding coordinator** |
|  | **Breastfeeding policy** |
|  | **Procedures for the BFHI 10 steps implementation** |
|  | **BFHI work plan** |
|  | **Staff training plan** |
|  | **Prenatal, Perinatal and Postnatal education plan** |
|  | **Data collection plan** |

*Information pertinent to BFHI certificate candidate hospital:*

|  |  |
| --- | --- |
| **Name of the hospital to which the Certificate applies** |  |
| **Name of the CEO** |  |
| **Job Title** |  |
| **Contact number** |  |
| **Email address** |  |

|  |  |
| --- | --- |
| **Name of the Hospital BFHI coordinator** |  |
| **Job title** |  |
| **Contact number** |  |
| **Email address** |  |

|  |  |  |
| --- | --- | --- |
| **BFHI committee Members** | | |
| **Name** | **Title** | **Email address** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Total Number of deliveries /years** |  |
| **Percentage of mothers who follow –up their pregnancy and deliver at your hospital** |  |
| **Does the hospital have prenatal clinics?** | **YES/NO** |
| **Does the hospital have a neonatal intensive care unit?** | **YES/NO** |
| **Does the hospital have post-natal follow –up clinics (Pediatric clinic or Primary health care)?** | **YES/NO** |

**I confirm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ that I fully support the implementation of**

**baby friendly standards (Updated BFHI 10 steps by WHO /UNICEF) and the Lebanese law** 47**/2008.**

**Hospital CEO Signature MOPH Signature**

**Date:**