

## **LACTATION SUPPORT PROGRAM FEEDBACK FORM**

### **For Supervisors and Colleagues of Breastfeeding Employees**

As you know, the company provides a lactation support program to assist breastfeeding employees with providing their milk to their infants. We value your feedback on ways the program can continue to improve to meet the needs of all employees.

How many colleagues or employees under your supervision are you aware of who are currently participating in the company lactation support program? \_\_\_\_\_

Have you attended an employee orientation or training event on the program?     yes     no

**How do you feel the following lactation program components have impacted the breastfeeding employee(s)?**

<b>PROGRAM COMPONENTS</b>	Positive Impact 3	No Impact Observed 2	Negative Impact 1
Availability of a lactation room for milk expression			
Opportunity to breastfeed baby at work			
Flexible breaks for milk expression			
Flexible return to work policy (ex: part-time, job sharing, telecommuting, flex-time, etc.)			
Work site education opportunities such as prenatal classes and monthly support groups			
Other: _____			

**How do you feel these same components impact the operation of your department?**

<b>PROGRAM COMPONENTS</b>	Positive Impact 3	No Impact Observed 2	Negative Impact 1
Availability of a lactation room for milk expression			
Opportunity to breastfeed baby at work			
Flexible breaks for milk expression			
Flexible return to work policy (ex: part-time, job sharing, telecommuting, flex-time, etc.)			
Work site education opportunities such as prenatal classes and monthly support groups			
Other: _____			

Please describe what you feel works BEST about the company's lactation support program.

Please describe what may NOT be working well about the company's lactation support program.

What suggestions or ideas do you feel would help improve the program?

Other comments:

Name (*Optional*) \_\_\_\_\_

Position/Title (*Optional*) \_\_\_\_\_

Department (*Optional*) \_\_\_\_\_