



ALPP Application for Renewal of Certification

Certified Lactation Counselor® (CLC®)

Name _____

Home Address _____

City _____ State _____ Zip _____

Credit Card Billing Address _____

Credit Card Billing City/State/Zip _____

Daytime Phone _____

Email _____

Date of CLC Certification _____

Location of CLC Examination _____

Payment Information

| CLC Recertification Fee Schedule | Price | Check One |
|--|-------|-----------|
| Early Recertification - completed application packet is received at least 2 months prior to expiration | \$102 | |
| Regular Recertification – completed application packet is received between 2 months prior to expiration date and actual expiration date | \$126 | |
| Late Recertification – completed application packet is received within 3 months following the expiration date | \$176 | |
| Total Amount Enclosed | | |

Send to:

Academy of Lactation Policy and Practice
 Department of Recertification – CLC
 PO Box 2170
 South Dennis, MA 02660
 OR fax to: (508)-833-6070



Method of payment:
(Full payment required)

- Check or Money Order (Please make checks payable to ALPP)
- Charge my: _____ MasterCard _____ Discover
_____ American Express _____ VISA

List your credit number below:

| | | | | | | | | | | | | | | | | | | | |
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Expiration Date (Month /Year)

| | | | |
|--|--|--|--|
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|--|--|--|--|

V Code*

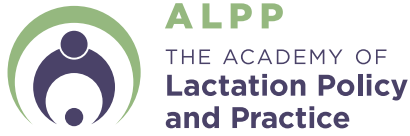
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Signature (as shown on credit card)

*3 numbers on back of card for MC/Visa/Discover; 4 numbers on front of card for AmEx

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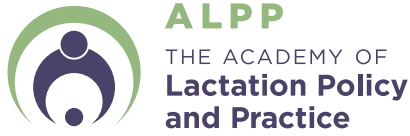
Name

| Date of Program | Program Name | Relevant Hours | Sponsoring Agency | Certificate Attached |
|----------------------|--------------|----------------|-------------------|----------------------|
| | | | | |
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| Total Relevant Hours | | | | |

Please make sure your name appears on all certificates. If your name was not printed on the certificate for you, please write it in. Any certificate received without a name will be considered invalid. It is your responsibility to prove you attended the training. Attach copies of all certificates. Please keep a copy for your records and print neatly. ALPP is not responsible for misdirected mail. Please allow up to six weeks for processing of recertification.

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Affidavit of Continuing Education (signature required)

I attest that I have completed the required hours of continuing education as I have stated in this application. I understand and agree that any false information provided by me may result in revocation of my CLC credential.

Signature:

Date:

Send to:

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Updated 3/3/2021



ALPP - Optional Demographic Survey

The information collected in this optional survey is for demographic purposes only. Our goal is to have the demographics of our Certified Lactation Counselors reflect the demographics of the United States. Your answers are completely confidential and will help us plan where to hold future courses and examinations.

NAME:

1. What is your gender?

Female Male Other

2. What is your age range?

18 - 24 25 - 34 35 - 50 50 +

3. How would you describe your ethnicity? (check all that apply)

Non-hispanic White or Euro-American Black, Afro-Caribbean, or African American
 Latino or Hispanic-American American Native or Alaskan Native
 East Asian or Asian American South Asian or Indian American
 Middle Eastern or Arab American Native Hawaiian or other Pacific Islander
 Other: _____

4. What language(s) do you speak (check all that apply)?

English French (incl. Cajun) Portugese Other 1: _____
 Spanish Haitian German Other 2: _____

5. What licenses and/or credentials do you hold? (check all that apply)

MD/DO/DC RN IBCLC CLC APRN or NP
 RD/LD Nutritionist OT CNM CPM PA CMA CNA
 SLP LPN Doula Childbirth Educator Community Health Worker
 Massage Therapist Volunteer Breastfeeding Counselor Peer Counselor
 Social Worker Other: _____

6. What is the highest level of education you have received?

Less than high school degree HS degree or edquivalent (GED)
 Some college, no degree Associate's degree
 Bachelor's degree BSN Graduate degree MPH

7. How long have you worked with mothers and babies?

Never One year or less 1 - 5 years 6 - 10 years
 11 - 15 years 16 - 20 years 20 + years

8. If you currently work with mothers and babies, which setting do you work in? (check all that apply)

Hospital - Labor and Delivery Hospital - Postpartum Hospital - NICU Birth Center
 Clinic (Family Outpatient) OBGYN Clinic Hospital - Other: _____
 Pediatric Office Private Practice Health Department WIC
 Military Community Health Home Visiting IHS NFP
 Head Start / Early Intervention / Healthy Start Other: _____