Financial Support for IBCLC

Date of Request:

Clinic Name:

WIC Coordinator:

Please complete this form for each person for whom you are requesting financial support.

All LA staff members who request financial support for IBCLC must sign the “continue to work agreement” form to receive financial support. If the costs are covered by the LA budget, submit a reimbursement request using the standard affidavit procedures. If costs are not covered by the LA budget, the SA will process payment after receipt of receipts, invoices, etc.

All Local Agency staff members who receive financial support must agree to write an article for the WIC newsletter and submit the article to the SA within 30 days of attending the training event.

Submit to the SA Training Coordinator by email to KDHE.KWICStaffChange@ks.gov, fax to 785-559-4242 or postal mail.

For State Agency Staff Use:

Date Request Received:

Approved: _____Yes  ________No

Amount of Financial Support Provided:

Signature:
Complete the following information for each person.

Person requesting financial support to become an IBCLC:

- Name & Job title:

- Percent Full Time Equivalent (FTE):

- Percent of Time Worked for WIC:

- How does the training relate to the person’s WIC job responsibilities?

- Justification for this course/class/training – why needed, benefit.

Funds requested for:

- Title of Coursework, Class or Training Event:

  Location:

  Date(s):

  Estimated Cost (Include explanation as needed for each bulleted item.)
  
  Remember: Salary is not covered under the special funds so must be covered by
  the LA regular WIC allocation.

- Registration Fee/Tuition:

- Travel: (Include type and list all travel expenses, including parking, tolls, etc. Maximum mileage reimbursement is the current allowance, usually announced annually in the January Information Memo)

- Lodging: (Include number of nights, rate, and taxes)

- Food Cost per day: _____ X _____ days = ____ total estimated food cost. (Food cost paid only w/ overnight stay)

- Total $ Requested: __________
If available, please attach a brochure or flyer about the training’s purpose, agenda, etc.

☐ 2. IBCLC exam cost (Note: Only the initial exam is eligible for funding)

- I have met all exam requirements:  Yes   No  (circle one)
  If no, explain how will meet requirements.

- Date of exam:

Estimated Cost (Include explanation as needed for each bulleted item.)

- Exam fee:

- Travel: (Include type and list all travel expenses, including parking, tolls, etc. Maximum mileage reimbursement is the current allowance, usually announced annually in the January Information Memo.)

- Lodging: (Include number of nights, rate, and estimated taxes)

- Food Cost per day _____ X _____ days = ______ total estimated food cost. (Food cost paid only w/ overnight stay)

- Total $ Requested: __________

If applying for Sections 1 and 2, what is the grand total dollar amount requested.
$ __________

Revised for 10/01/2019
Continue to Work Agreement

I, ______________________________, have read and understand the Kansas Nutrition and WIC Services policy ADM: 11.02.00 and will receive funding to register for the International Board Certified Lactation Consultant (IBCLC) certification exam. I agree to continue to work for a Kansas WIC clinic for one year after taking the IBCLC exam, in April or October (please circle month) of 20__ or reimburse Kansas Nutrition and WIC Services for the exam registration fee.

________________________________________
Signature of staff member taking IBCLC exam

________________________________________
Signature of immediate supervisor or LA WIC Coordinator

________________________________________
Signature of State Agency WIC Training Coordinator