Safe Sleep Star Application
KIDS Network Safe Sleep Instructor Project

Email this completed form to edirector@kidsks.org

Select which level site is applying for: ☐ Bronze ☐ Silver ☐ Gold
Instructions will be provided on the requirements for the selected level from the KIDS Network.

Safe Sleep Instructor Name: _____
First Last

Date of Clinic Safe Sleep Training (Anticipated or Actual): _____

Provider's Office Name: _____

Address: _____
Street City Zip

Type of Office: ☐ Pediatric ☐ Obstetric ☐ Family Medicine ☐ Other: _____

Average Number of Visits Monthly: _____ infants (0-12 months) _____ pregnant women

Number of Providers in Clinic: _____

Number of Providers Participating in Safe Sleep Star: _____

Clinic Contact: _____ _____
First Last Title

_____ _____
Email Phone

Levels for Outpatient Clinic