

REGISTRATION FORM

Please register early in your pregnancy. Mail this form with payment and a stamped, self-addressed envelope (for US mail confirmations) to:

EXPECTANT PARENTS ORGANIZATION
 271 Woodland Pass, Suite 214,
 East Lansing, MI 48823
 Phone: 517.337.7365 FAX: 517.337.7584

WOMAN'S FIRST & LAST NAME	AGE	RACE <input type="checkbox"/> African American <input type="checkbox"/> Multi or Bi-Racial <input type="checkbox"/> Native American <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other _____	MARITAL STATUS ___ M ___ S ___ W ___ D
PARTNER'S FIRST & LAST NAME	AGE	RACE <input type="checkbox"/> African American <input type="checkbox"/> Multi or Bi-Racial <input type="checkbox"/> Native American <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other _____	COMBINED FAMILY INCOME <input type="checkbox"/> \$ 0-24,000 <input type="checkbox"/> \$42,001-51,000 <input type="checkbox"/> \$24,001-33,000 <input type="checkbox"/> \$51,001 or above <input type="checkbox"/> \$33,001-42,000
ADDRESS		CITY	ZIP CODE
HOME PHONE		WORK PHONE	EMAIL ADDRESS
		<input type="checkbox"/> Please confirm my registration by email <input type="checkbox"/> Please confirm my registration by US mail	
DUE DATE	FIRST BABY	PHYSICIAN/MIDWIFE	HOSPITAL OF DELIVERY
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
WOMAN'S EDUCATION		WOMAN'S OCCUPATION	
PARTNER'S EDUCATION		PARTNER'S OCCUPATION	
HEALTH INSURANCE (Please include a copy of your insurance card.) <input type="checkbox"/> Physicians Health Plan (PHP) <input type="checkbox"/> Sparrow Physicians Health Network (SPHN)			
Group#: _____ Subscriber #: _____ Birth Date of Cardholder: _____			
<input type="checkbox"/> Four-Week Evening Prenatal Combo Location: Lansing/East Lansing (1 st & 2 nd Choice): ___ Mon ___ Tue ___ Wed ___ Thu Other Areas: <input type="checkbox"/> St. Johns <input type="checkbox"/> Charlotte <input type="checkbox"/> Holt		PAYMENT METHOD: <input type="checkbox"/> Check <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard Name on Card: _____ Account No. _____ Exp Date ___/___/___ Signature _____	
<input type="checkbox"/> Three-Week Saturday Morning Series <input type="checkbox"/> One-Day Saturday Prenatal Seminar <input type="checkbox"/> e-Learning Prenatal Class <input type="checkbox"/> Teen Prenatal Series <input type="checkbox"/> Sibling Class (List children's first and last names and ages:) _____		<input type="checkbox"/> Preparing for Birth <input type="checkbox"/> Newborn Care & Feeding <input type="checkbox"/> Labor & Delivery <input type="checkbox"/> Multiples Class <input type="checkbox"/> Breastfeeding Class	
		<input type="checkbox"/> I would like information about financial assistance sent to me. <input type="checkbox"/> I would like to make a tax-deductible contribution to support the Scholarship Program.	
		Class Fees: \$ _____ Scholarship Fund Contribution: \$ _____ Total: \$ _____	