

Childbirth Class Registration Form

Name: _____ Birth date: _____

Name of MD/Midwife: _____

Address: _____ Daytime Phone: _____

City: _____ State: _____ Zip: _____

Expected Delivery Date: _____

Title and date of class:

1st Choice: _____

2nd Choice: _____

*Every effort will be made to accommodate your first date of choice;
however, if the class is full, you will be enrolled in the 2nd date of choice*

Credit Card Number: _____ Expiration Date: _____

Number of people to attend: _____

Comments: _____

*If you need to cancel or reschedule please call 24 hours in advanced or you will be
charged a \$50 no show/cancellation fee.*

For further information call (505) 843-6168, extension 3027

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