Childbirth Education Class Registration Form

Please enroll me for the following class(es):

Class Name	Session Dates	Fee (If Applicable)
		$
		$
		$
		$
	Total Amount Enclosed	$

Name _____

Mother's Occupation _____

Partner's Name _____

Partner's Occupation _____

Mother's Age _____ Partner's Age _____

Address _____

City/State/Zip Code _____

Telephone:
(Days) _____ (Evenings) _____

Due Date _____ No. Pregnancies _____

Mother's Doctor _____

Breastfeeding: ☐ yes ☐ no
Please list children's name(s), age(s) and sex if registering for Sibling/Family or Breastfeeding:

_____

_____

Dietary Restrictions/Physical Limitations _____

Payment Options:

☐ Personal Check ☐ MasterCard ☐ Visa

Credit Card Number _____ Exp. Date _____

MAIL THIS REGISTRATION FORM AND YOUR CHECK PAYABLE TO:

Methodist Medical Center of Illinois
Attention: Childbirth Education Class Registration
221 N.E. Glen Oak Avenue
Peoria, Illinois 61636-0002