

Please register early in your pregnancy. Expectant Parents Organization Phone: 517-887-7000
 Please mail this form with payment and a stamped, self-addressed envelope (for US mail confirmations) to: EPO 3315 S Pennsylvania Ave, Lansing MI 48910

REQUIRED INFORMATION

<p>*Mother's First & Last Name: _____ Age _____</p> <p>Race: <input type="checkbox"/> African American <input type="checkbox"/> Multi or Bi-Racial <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other _____</p>	<p>Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p>
<p>Partner's First & Last Name : _____ Age _____</p> <p>Race: <input type="checkbox"/> African American <input type="checkbox"/> Multi or Bi-Racial <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other _____</p>	<p>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"/> \$33,001-42,000 <input type="checkbox"/> \$51,000 or above</p>
<p>Address _____ City _____ Zip Code _____ County _____</p>	
<p>*Home/Cell Phone() _____ WorkPhone() _____ - *Email Address _____</p>	
<p>*Due Date _____ First Baby? <input type="checkbox"/> Yes <input type="checkbox"/> No Twins? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician/Midwife _____ Hospital of Delivery _____</p>	
<p>Mother's Education</p>	<p>Mother's Occupation</p>
<p>Partner's Education</p>	<p>Partner's Occupation</p>
<p>Health Insurance: <input type="checkbox"/> Physicians Health Plan (PHP) <input type="checkbox"/> Sparrow Physicians Health Network (SPHN) <input type="checkbox"/> _____</p>	
<p>Group # _____ Subscriber # _____ Birth Date of Cardholder _____</p>	
<p style="text-align: center;">Check Class and enter Series Start Date</p> <p><input type="checkbox"/> Prenatal Series (Evening) _____ <input type="checkbox"/> (Saturday Morning) _____</p> <p><input type="checkbox"/> One-Day Saturday Prenatal Seminar _____</p> <p><input type="checkbox"/> Labor & Delivery _____</p> <p><input type="checkbox"/> Labor & Delivery Express _____ <input type="checkbox"/> e-Class Prenatal Program _____</p> <p><input type="checkbox"/> Best Newborn Care Class Ever _____</p> <p><input type="checkbox"/> Infant Safety 101 _____ <input type="checkbox"/> Breastfeeding Class _____</p> <p><input type="checkbox"/> Childbirth Comprehensive: <input type="checkbox"/> Labor & Delivery _____ <input type="checkbox"/> Best Newborn Care Class Ever _____</p>	<p>Payment Method: <input type="checkbox"/> Check <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard</p> <p>Name on Credit Card: _____</p> <p>Card Number _____ - _____ - _____</p> <p>Three digit security code: _____ Expiration Date: _____ / _____</p> <p>Signature _____</p> <p><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 EPO Scholarship Fund.</p> <p>Class Fees: \$ _____ Scholarship Fund (tax deductible) Donation: \$ _____</p> <p>Total: \$ _____</p>

