McLaren Central Michigan

Family Birthing Center
Childbirth Education
Medicaid Participant Form

PARTICIPANT INFORMATION		
(Please Print)		
Name		**M.I.**
Address		**Apt. #**
City	**State**	**Zip Code**
Date of Birth	**Phone Number**	
Medicaid Number		
Doctor	**Expected Date of Delivery**	

Instructor Completes This Section

Year _____ **# Class Sessions** _____ **# Hours Per Session** _____

Dates Participant Attended:

_____ _____
Session 1 **Session 2**

The participant has attended Childbirth Education on the above dates.

_____ _____
Instructor's Signature **Date**

_____ _____
Participant's Signature **Date**

INSTRUCTORS:

- Please enter the dates of each session the participant attended and sign where indicated.
- Return the completed form to Health Promotions to be submitted for payment.
- The participant is required to attend at least half of the course sessions to receive credit. Medicaid reimbursement for the course is determined by participant attendance.

McLaren CENTRAL MICHIGAN

1221 South Drive . Mt. Pleasant, MI 48858 . (989) 779-5606