REGISTRATION FORM Please register early in your pregnancy. Expectant Parents Organization Phone: 517-337-7365

If you do not provide an e-mail address please mail this form with payment and a stamped, self-addressed envelope (for US mail confirmations) to: P O BOX 4790 East Lansing, MI 48826-4790

Woman's First & Last Name Age Race: □ African American □ Multi or Bi-Racial □ Caucasian (White) □ Hispanic □ Native America □ Asian □ Other _____	Marital Status □ Married □ Single □ Widowed □ Divorced
Partner's First & Last Name Age Race: □ African American □ Multi or Bi-Racial □ Caucasian (White) □ Hispanic □ Native America □ Asian □ Other _____	Combined Family Income □ $ 0-24,000 □ $42,001-51,000 □ $24,001-33,000 □ $33,001-42,000 □ $51,000 or above

Address	City	Zip Code	COUNTY

Home Phone	Work Phone	Email Address
( ) -	( ) -	

Due Date	First Baby	Physician/Midwife	Hospital of Delivery
	□ Yes □ No		

Woman's Education	Woman's Occupation
Partner's Education	Partner's Occupation

Health Insurance □ Physicians Health Plan (PHP) □ Sparrow Physicians Health Network (SPHN)

Group # _____ Subscriber #_____ Birth Date of Cardholder _____

Enter Class or Series Start Date	Payment Method: □ Check □ VISA □ MasterCard
□ Prenatal Series (Evening) _____ □ Prenatal Series (Saturday Morning)_____ □ One-Day Saturday Prenatal Seminar _____ □ The Best Newborn Care Class Ever _____ □ Newborn Care & Feeding _____ □ e-Class Prenatal Program _____ □ Breastfeeding Class _____ □ Labor & Delivery Refresher _____ □ Other _____	Name on Credit Card: _____ Card Number _____-_____-_____-_____ Three digit security code: ___-___-____ Expiration Date: _____/_____ Signature _____ □ I would like information about financial assistance sent to me. □ I would like to make a tax-deductible contribution to support the EPO Scholarship Fund. Class Fees: $_____ Scholarship Fund Contribution: $ _____ Total: $ _____