MaternityWise Membership Request Form

Name: ____

Mailing Address: ____

City: ______________________ Province: ________________ Postal Code: _____________

Phone: _____________________________ Alt. Phone: _____________________________

Email: ____

Initial Below for All that Apply:

__________ I will help promote the MaternityWise program in my area.

__________ I am a Trust Birth Facilitator.

__________ I am a Cross-Over Certification Doula.

__________ Please send me the Postpartum Doula Certification Packet

__________ I would like to attend a training in my area.

Please mail this form and your $45 American payment to:

MaternityWise – Membership
PO Box 774, Lester Prairie, MN 55354

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Sign Date