CLASS REGISTRATION FORM

Thank you for your interest in our classes and programs. If you wish to pay for your enrollment by check, please complete this form and return it with your check **made payable to Affinity Health System** and send it to:

Affinity Nurse*Direct* ✧ PO Box 8006 ✧ Appleton, WI 54912-8006

***Please note*: You will not be enrolled in your selected class until we receive your check and registration form. You may want to consider paying by credit card – either online at www.affinityhealth.org or through Affinity Nurse*Direct* at 1-800-362-9900 to guarantee your registration.**

If your choice for a class is filled upon receipt of your registration form and payment, we will call you to arrange placement in another class, based on availability.

Participant's Information

Last Name: _____ First Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ ❒ Male ❒ Female

Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

E-mail address to send confirmation to: _____

Name of your health insurance company: _____

If applicable – Name of person attending class with you: _____

If applicable – Name of parent or guardian: _____

If enrolling in childbirth classes, please include:

Provider's Name: _____ Due Date: _____

FIRST CHOICE:

Class Name: _____

Class Date: _____ Class Time: _____ Class Fee $ _____

Location: ❒ St. Elizabeth ❒ Mercy Medical Center ❒ Calumet Medical Center ❒ _____

SECOND CHOICE or ADDITIONAL CLASS:

Class Name: _____

Class Date: _____ Class Time: _____ Class Fee $ _____

Location: ❒ St. Elizabeth ❒ Mercy Medical Center ❒ Calumet Medical Center ❒ _____

THIRD CHOICE or ADDITIONAL CLASS:

Class Name: _____

Class Date: _____ Class Time: _____ Class Fee: $ _____

Location: ❒ St. Elizabeth ❒ Mercy Medical Center ❒ Calumet Medical Center ❒ _____