

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 the address listed below.

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 NurseDirect 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 Information

Last Name: _____ First Name: _____
 Address: _____
 City: _____ State: WI Zip Code: _____
 Gender: Male Female
 Birth Date: _____
 Phone Number: () _____ - _____ Alternate Phone Number: () _____ - _____
 E-mail Address for Confirmation: _____

First Choice

Class Name: _____ Class Date: _____
 Class Time: _____ Class Fee: \$ _____
 Class Location:
 St. Elizabeth Hospital Mercy Medical Center Calumet Medical Center
 Other: _____

Second Choice or Additional Class

Class Name: _____ Class Date: _____
 Class Time: _____ Class Fee: \$ _____
 Class Location:
 St. Elizabeth Hospital Mercy Medical Center Calumet Medical Center
 Other: _____

Third Choice or Additional Class

Class Name: _____ Class Date: _____
 Class Time: _____ Class Fee: \$ _____
 Class Location:
 St. Elizabeth Hospital Mercy Medical Center Calumet Medical Center
 Other: _____

If applicable, name of person who will be attending class with registrant: _____
 If applicable, parent or guardian name: _____

If enrolling for childbirth classes, please include:
 Provider's Name: _____ Due Date: _____

Please return this form with your check to:
 Affinity NurseDirect
 P.O. Box 8006
 Appleton, WI 54912-8006