

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

Sign

Date