MATERNITY CENTER
160 No. Midland Avenue
Nyack, NY 10960-1998
Tel: 845-348-2639

REGISTRATION FORM
CHILDBIRTH / INFANT CARE EDUCATION

Partner:______________________

NAME First_________________________Last_________________________

ADDRESS Number and Street____

City______________________State__________Zip______________

PHONE Home_________________Work______________Cell______________

EMAIL:____Due Date: ____________

LAMAZE

[ ] Childbirth preparation	6 weeks	Date________	Time______	$175
[ ] Accelerated childbirth preparation	2 days	Date________	Time______	$175
[ ] Childbirth Refresher	1 day	Date________	Time______	$ 75

PRENATAL CLASSES **(Discount for all 4 classes: $175)**

[ ] Infant care	Date_________	TIme_____	$ 50
[ ] Infant nutrition	Date_________	Time_____	$ 50
[ ] Breastfeeding basics	Date_________	Time_____	$ 50
[ ] Infant / Child CPR	Date_________	Time_____	$ 50

TOTAL ___________

PAYMENT METHOD

[ ] CHECK CREDIT CARD [ ] American Express [ ] Discover Card

[ ] Visa [ ] Mastercard

Credit card number____________________

Expiration Date_______________ (month/year)

Security code________________________

Discover, Visa, Mastercard: 3 digit number on the back of the card at the end of the signature panel. **Am Ex Optima:** 4 digit number on face of card above and to the left of the card number

Card Holder name and address if different from above:

____

____

NOTE:
Full refunds will be given for cancellation prior to the 1st day of class only if withdrawal is due to early delivery. A 20% processing fee will be applied to cancellations for any other reason. Refunds for cancellations after classes have begun will be pro-rated

Card Holder Signature____

Please mail completed registration form and check or credit card information to the above address c/o Eileen Walker, Mother/Baby Unit
Visit www.nyackhospital.org, enter Calendar section, and click on classes that interest you to get information regarding class.