

HIGHLAND HOSPITAL OB EDUCATION

REGISTRATION FOR CLASSES

Please complete this form and return with payment. You will receive confirmation of your classes by mail.

Your Name: _____ **Age:** _____

Class Companion's Name: _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone (Home): _____ **Phone (Daytime):** _____

Hospital for Birth: _____ **Due Date:** _____

Ob/Gyn or Family Practice Doctor: _____

Health Care Insurance & ID Number: _____

1) Name of Class: _____ **Fee:** _____

Preferred Dates: _____

2) Name of Class: _____ **Fee:** _____

Preferred Date(s): _____

**Please Return To: Highland Hospital OB Education
1000 South Ave., Box 112
Rochester, NY 14620**

Please call 473-2229 with any questions or to charge by phone.