PROVIDENCE Health & Services

Return to Class Schedules

Please use this form to register by mail or fax.

Print and mail to:

Providence Health Education Services
9340 SW Barnes Road, Suite 200
Portland, OR 97225

Or Fax: (503) 216-2039

Name _____
Address _____
City _____
State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

If you are a member of one of the following health plans, please indicate:
Providence Health Plan __ Providence Preferred __ Providence Employee __ Senior __

1. Class _____ Fee $_____
Date _____ Time _____
Location _____

2. Class _____ Fee $_____
Date _____ Time _____
Location _____

If registering for childbirth education classes, please complete the following:
Due date: _____
Your doctor: _____Partner's Name:_____
Where will your baby be born: _____

TOTAL ENCLOSED $ _____

Please make checks payable to Providence Health & Services.

Bill me through: __ Visa __ MasterCard __ Discover

Card # _____
Expiration Date _____ _____ _____
Signature _____