



Membership Registration

Personal Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Professional Information

Business Name: _____

Business Phone: _____ Credentials: _____

Website Address: _____

Business Address: _____

Services you would like to advertise you provide:

VBAC Vaginal Twin Delivery Vaginal Breech Birth WWC outside of PN/PP

Other _____

Type of Annual Membership:

Professional Member \$100 Associate Member \$75 Supporting Member \$30

Form of Payment:

_____ Check enclosed (made payable to WARM)

_____ Payment made via PayPal (to warmmidwife@gmail.com) on (date) _____

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