

Counseling Associates of Metropolitan Washington

PROVIDING SUPPORT TO WOMEN & THEIR FAMILIES

Registration

Please Print

NAME: _____

ADDRESS: _____

PHONE: _____ (Home)

_____ (Work)

_____ (Cell)

EMAIL: _____ YOUR AGE: _____

Please register me for:

FIRST TIME MOMS WITH BABIES GROUP (AM)
Due Date/Date of Birth (*circle one*) _____

MOMS ONLY GROUP (PM)
Due Date/Date of Birth (*circle one*) _____
Other children? Yes No Ages: _____

I have enclosed:

Full Payment (\$260)

Please complete form, print and mail to:

*Counseling Associates of Metropolitan Washington
4833 Bethesda Avenue, Suite 204
Bethesda, MD 20814*