

SISTERS IN BIRTH ACADEMY APPLICATION

Please type, sign, and email the application form to sibirth0@gmail.com. No application fee.

Full name:	Last First M.I.	Date:	
Address:	Street address Apt/Unit #	Phone:	
	City State Zip Code	Email:	

Choose Your Program of Interest	☐ Doula Certification Program	☐ Maternal and Child Health Leadership Certificate Program
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Choose a Program and Date of Enrollment:

Doula Certification Program: ☐ Cohort 1 - January 2027 - October 2027 ☐ Cohort 2 - June 2027 – February 2028

Maternal and Child Health Leadership Certification Program: ☐ Cohort 1 – August 2027 – January 2028

Are you a citizen of the United States?	Yes ☐	No ☐	Do you speak English fluently?	Yes ☐	No ☐
Do you have access to a reliable computer and internet?	Yes ☐	No ☐			

Education

GED	Yes ☐	No ☐	ID Number		Testing State/Year	
HiSet Diploma/Certificate	Yes ☐	No ☐	ID Number		Testing State/Year	
High School			Address:			
From:		To:	Did you graduate?	Yes ☐	No ☐	Diploma:
College:			Degree			
From:		To:	Did you graduate?	Yes ☐	No ☐	Degree:
Other:			Degree			
From:		To:	Did you graduate?	Yes ☐	No ☐	Degree:

Employment

Are you employed full-time? Yes ☐ No ☐ What is your profession or job title? _____
Do you have professional experience in Public Health ☐ or Healthcare ☐

Disclaimer and signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to enrollment, I understand that false or misleading information on my application or interview may result in my release.

Signature:		Date:	
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