SISTERS IN BIRTH ACADEMY APPLICATION

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

Full name: _____ Date: _____
Last First M.I.

Address: _____ Phone: _____
Street address Apt/Unit #

_____ Email: _____
City State Zip Code

Choose Your Program of Interest ☐ **Doula Certificate Program** ☐ **Maternal and Child Health Leadership Certificate Program**

Choose a Program and Date of Enrollment:

Doula Certificate Program: ☐ Cohort 1 - January 2027 - October 2027 ☐ Cohort 2 - June 2027 – March 2028

Maternal and Child Health Leadership Certificate Program: ☐ Cohort 1 – August 2027 – April 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: _____