

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 Certificate Program	☐ Maternal and Child Health Leadership Certificate Program
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Choose a Period of Enrollment and Class Schedule:

Doula Certificate Program : ☐ February 2027 - November 2027 ☐ Monday/Wednesday 6:30 pm - 8:30 pm
☐ Tuesday/Thursday 6:30 pm - 8:30 pm

Maternal and Child Health Leadership Certificate Program: ☐ August 2027 – April 2028 ☐ Monday/Thursday 6:30 pm - 8:30 pm (only)

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:
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From:	To:	Did you graduate?	Yes ☐ No ☐	Diploma:
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College:	Degree
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From:	To:	Did you graduate?	Yes ☐ No ☐	Degree:
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Other:	Degree
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From:	To:	Did you graduate?	Yes ☐ No ☐	Degree:
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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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