

CALIFORNIA ASSOCIATION OF MIDWIVES

MEMBERSHIP APPLICATION

NAME _____ NEW RENEWAL

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONES _____ COUNTY _____

E-MAIL _____

WEBSITE URL _____

Midwives: Would you like to be listed on the referral list? YES NO

MEMBERSHIP CATEGORIES

VOTING MEMBER

MIDWIFE

Check any that apply: LM CNM PA CPM

Annual income: under \$30,000/over \$30,000

1 year \$75/\$100 2 year \$140/\$190 3 year \$225/\$280

STUDENT MIDWIFE \$50/YEAR

NON-VOTING MEMBER

ASSOCIATE MEMBER \$50/YEAR

Birth Professional (Doula, Childbirth Ed, Lactation Consultant)

Other Health Care Professional

FRIEND OF MIDWIVES \$25/YEAR \$100/5 years

DONATIONS: \$1000 \$500 \$100 \$50 \$25 OTHER \$ _____

MAIL TO:

California Association of Midwives

P. O. Box 460606

San Francisco, CA 94146-0606

Or join online at <http://www.californiamidwives.org>