



GPMOMC Membership Form

Name: _____

Address: _____

Phone: _____

Email: _____

Names and birthdate(s) of children:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Would you be agreeable to having the above information listed in a directory to be distributed to Club members only? Please circle: YES NO

What is your professional/career background? _____

How did you find out about GPMOMC?

(circle one, please specify hospital or clinic by name):

website hospital _____

friend clinic _____

other _____

Membership fees: \$20 for the year (year begins in September),
\$10 if joining halfway through the year (February or later).

Please make check payable to GPMOMC and return with this form to:

Greater Portland Mothers of Multiples
459 Ludlow Street
Portland, ME 04102